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SCIENTIFIC ARTICLES

Induction of Labor by Rupture of the Membranes in Private Practice, *Eleanor Scott, M.D.* and *E. P. H. Harrison, Jr., M.D.* 399
Psychotic or Delinquent? Case Reports of Twenty-One Girls Transferred from Training School to State Hospitals, *Rachel K. Gundry, M.D.* 403
Common Feeding Problems in Children, *Mary L. Hayleck, M.D.* 409
Brucellosis: The Work of M. Ruiz Castaneda, M.D. and The Medical Research Institute, Mexico City, D.F., *Lydia Allen DeVilbiss, M.D.* 412
Brachial Palsy Following Gynecologic Surgery: Case Report, *Eleanor Scott, M.D.* 415

FEATURE ARTICLES

Woman's Medical Society of Maryland: The History of Banch Three, *P. S. Bourdeau-Sisco, M.D.* 417
Woman As a Social Force, *Ellen C. Potter, M.D.* 421
The American Women's Hospital in Greece, *Esther P. Lovejoy, M.D.* 423

REPORTS OF PROCEEDINGS

International Congress of Dermatology, *Spenser Scovell, M.D.* 419

REGULAR FEATURES

World Health Organization 420
Opportunities for Women in Medicine 424, 426
Album of Women in Medicine
NELLE S. NOBLE, *M.D. Marcelle Bernard, M.D.* 430
CLARIBEL CONE, *M.D., Bertha Tapman Shamer, M.D.* 431
News of Women in Medicine 433
These Were The First, *Elizabeth Bass, M.D.* 432
Book Notices 437
Current Publications 439

EDITORIAL

The JOURNAL and the Branches, *Ada Chree Reid, M.D.* 424

AMERICAN MEDICAL WOMEN'S ASSOCIATION

President's Message, *Evangeline E. Stenhouse, M.D.* 425
New Members 436
Directory: Changes of Address 436

MISCELLANEOUS

Editorial Board ..... Adv. p. 4
Officers of the A.M.W.A. ..... Adv. p. 6
Standing Committees ..... Adv. p. 8
Branch Officers ..... Adv. p. 12
Index to Advertisers ..... Adv. p. 11
Scientific News Notes ..... Adv. p. 16
Editorial Forecast ..... Adv. p. 19

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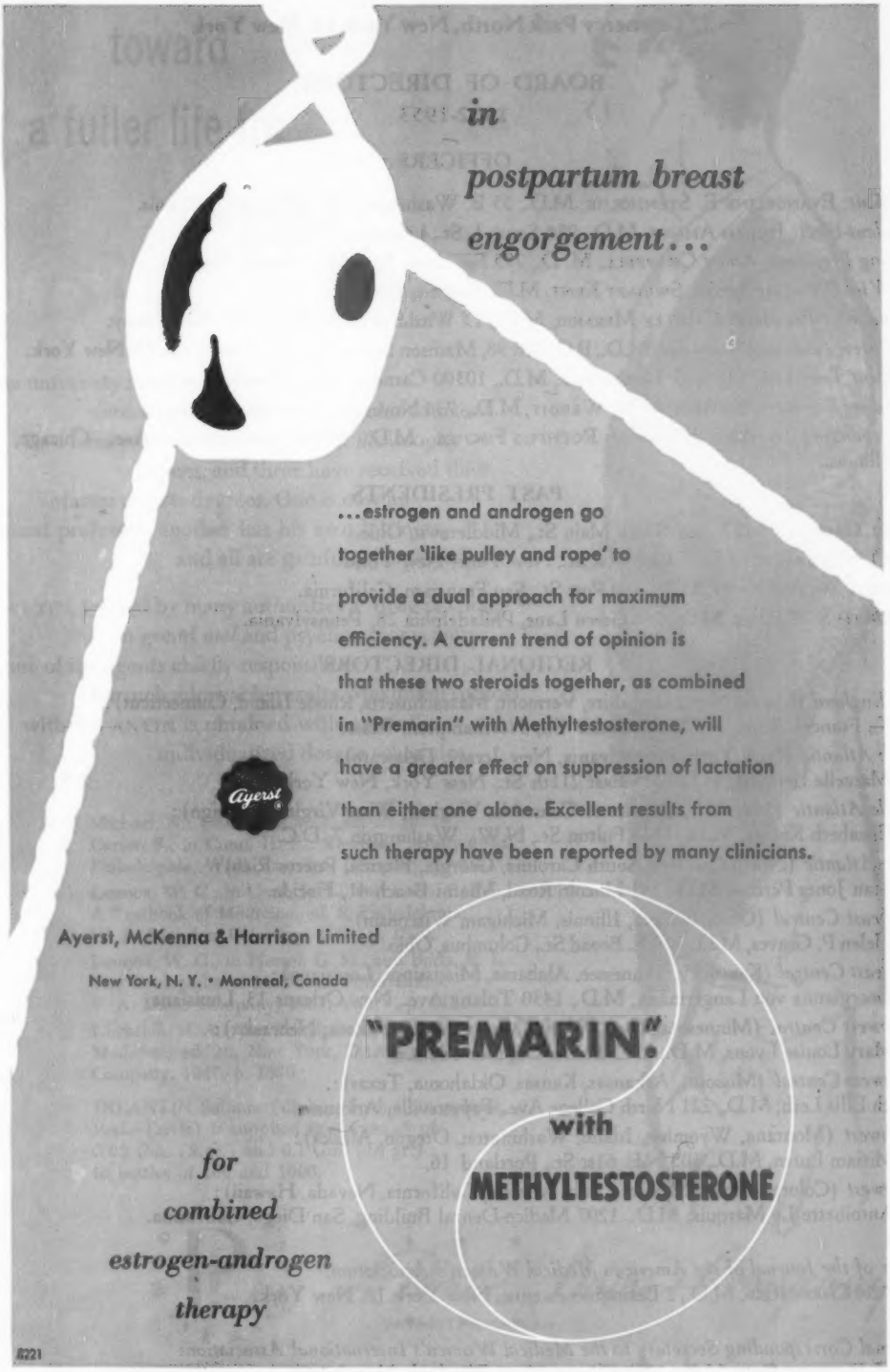
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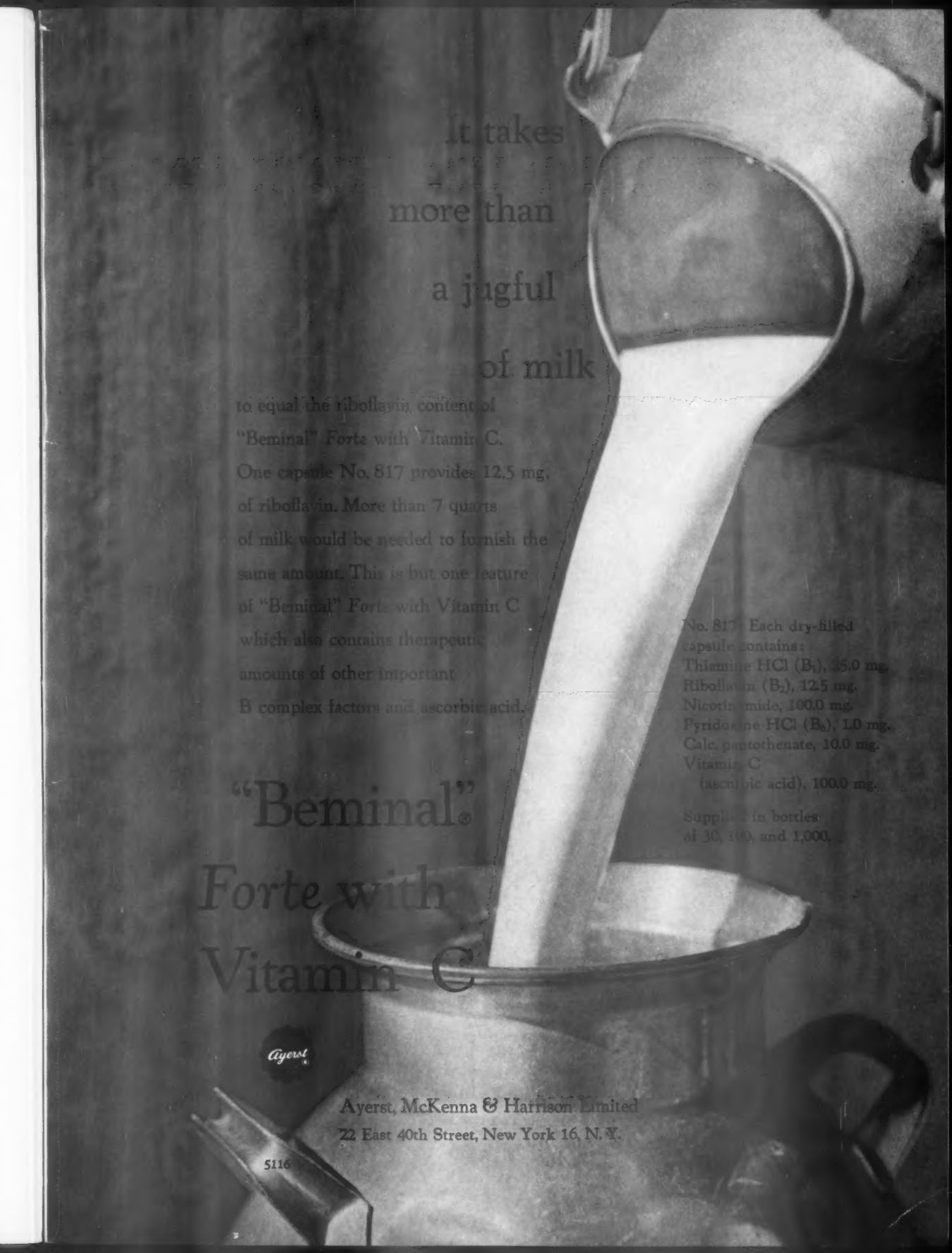
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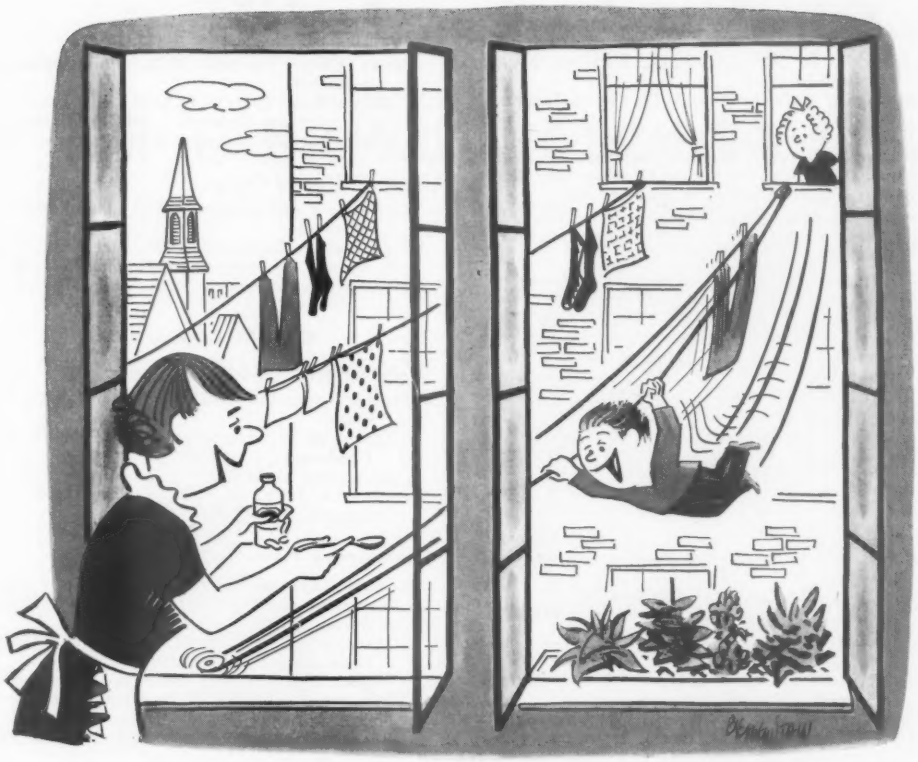

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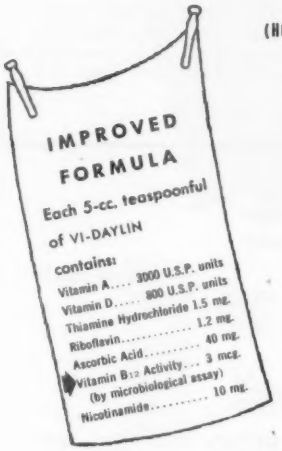
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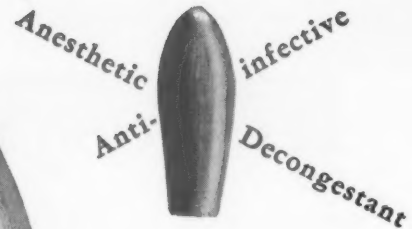

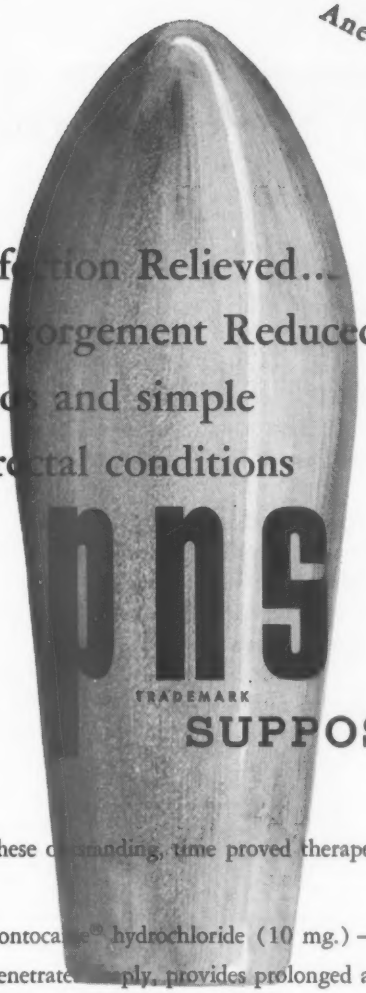

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VOLUME 7 NOVEMBER 1952 NUMBER 11

Induction of Labor by Rupture of the Membranes in Private Practice

Eleanor Scott, M.D., and Edmund P. H. Harrison, Jr., M.D.

THE PROBLEM of induction of labor by artificial rupture of the membranes has been discussed in a number of papers in recent literature. On reviewing this literature the reader is struck by the wide differences in opinion expressed by the various authors on the subject. The extremes of difference are expressed on the one hand by Dieckmann and McCready[1] who state that "it is inevitably followed by increased maternal and fetal mortality and morbidity regardless of how carefully the cases are selected," and on the other by Rucker[2] who, in a discussion of Roblee's paper, said that he had done a series of 4,045 inductions with no increase in puerperal morbidity, neonatal deaths, or prolapse of the cord.

Complications have been said to be an increased number of prolonged labors and uterine inertia, increased puerperal morbidity, prolapse of the cord, increased stillbirth and neonatal mortality rate.

Dr. Scott is Obstetrician at Johns Hopkins Hospital, Associate Attending Obstetrician and Gynecologist, Franklin Square Hospital, and Assistant Attending Obstetrician at South Baltimore General Hospital and Sinai Hospital. Dr. Harrison is Obstetrician at Johns Hopkins Hospital and Visiting Obstetrician at Hospital for the Women of Maryland, Union Memorial Hospital, and Sinai Hospital.

The conflicting statements made in the literature prompted us to analyze a series which consisted of all the inductions performed by one of us (E.P.H.H., Jr.) at Johns Hopkins Hospital, on private patients, during the years 1931 to 1945. Inductions were carried out in 193 of 484 deliveries or in 23 percent of all deliveries performed by him. Of the 193 inductions, 160, or 82.9 percent, were done as an elective procedure, whereas 33, or 17.1 percent, were carried out as a result of various indications. Table I shows the reasons this procedure was done in the indicated cases.

Induction of labor was successful in 100 percent of the cases. The longest latent period was 41 hours. The average latent period was 2 hours 12 minutes, but the modal latent period was 30 minutes. The median latent period was 1 hour 15 minutes. The latent periods were 2 hours or less in 78.6 percent

TABLE I
Reasons for induction of labor in 33 cases

INDICATION	NO. OF CASES
Acute hydramnios	2
Previous precipitate delivery	1
Preeclampsia	16
Excessive size infant in previous delivery	2
Pyelitis	2
Post maturity (1-3 weeks)	7
"Discomfort of patient"	1
Domestic problems	1
Antepartum bleeding from uterus at 26 weeks	1

TABLE II

Average lengths of labor: induced patients compared with total white patients

TYPE OF PATIENT	AVERAGE LENGTH OF LABOR IN HOURS	
	Induction Series (1931-1945)	White Patients (1937-1945)
All patients	5.78	10.59
Primipara	7.70	13.04
Multipara	3.97	8.15

of the cases. In 97.93 percent the latent periods were less than 12 hours, and 98.96 percent of the patients went into labor within 24 hours. There were only two patients, or 1.04 percent, who had latent periods over 24 hours: one 28 hours 35 minutes, and one 41 hours.

To determine whether induction of labor increases the incidence of the several complications of labor often attributed to it, a comparison of this series of inductions has been made with the average percentages of these complications found in a comparable series of white deliveries at the Johns Hopkins Hospital for the years covered by this study. Whenever available, the figures for the white private patients have been used. In the earlier years these were not available, as the statistics were compiled on the basis of total white patients. The figures for the colored patients have been excluded in this comparative study, as there is a definite increase of complications such as puerperal morbidity, prolonged labors, maternal mortality rate, and stillbirth rate in the colored patients, probably due to greater incidence of contracted pelvis, poor hygienic living conditions, and other conditions.

Table II shows a comparison of the average length of labor for the 193 induced cases with the average length of labor of 8,470 white deliveries at Johns Hopkins Hospital as reported for the years 1937 through 1945 by Trent Busby.[3] Busby points out in his article that the average length of labor is sometimes misleading, as it is weighted by a few very long labors. He points out that the mode (the length of labor which most patients had) and the median (the length of labor in which half the patients fall above and half below) are more significant figures than those of the average length of labor.

Table III shows a comparison of our series with his on that basis.

So we find that mean, modal, and median lengths of labor tend to be shorter in the induced cases than in the white patients as a whole, at Johns Hopkins Hospital. Of course, many of these induced patients were selected as to a favorable cervix, and would be expected to have relatively short labors if allowed to go into labor spontaneously.

Keettel, Diddle, and Plass[4] found that labors which exceeded 30 hours were more than two and a half times as common in a group of induced patients as they were in a group of spontaneous labors.

Eastman[5] surveyed the total ward group of deliveries for the Johns Hopkins Hospital from 1936 to 1945 and found that labors over 24 hours occurred in an average of 8.3 percent, while 4.8 percent exceeded 30 hours. In our series of inductions 1.5 percent of the labors were over 24 hours, and 1 percent over 30 hours.

Thus we find that labors over 30 hours were almost five times as frequent in the ward group of patients at Johns Hopkins Hospital as labors in the series of induced private patients. This is not a true comparison, however, as colored patients are included in Eastman's[5] study, and it has been found that, in general, colored patients tend to have somewhat longer labors than white patients. It could also be said that since the Johns Hopkins Hospital is a teaching hospital, it receives more of the complicated cases than would be sent in an unselected manner to a non-teaching general hospi-

TABLE III

Mode and Median Lengths of Labor: Induced Patients Compared With Total White Patients

TYPE OF PATIENT	LENGTHS OF LABOR (IN HOURS)	
	Induction Series	White Patients
Modal labor —primipara	3.5	7
—multipara	2.5	4
Median labor—primipara	5.5	10.59
—multipara	3.5	6.21

TABLE IV
Complications in Mature Deliveries: Induction Series Compared to Total Private Deliveries

COMPLICATIONS	Induction Series Mature deliveries only (percent)	Private Mature Deliveries 1937-1945 (percent)
Puerperal morbidity	6.0	7.6
Postpartum hemorrhage	0.5	3.6
Cesarean section	0.5	6.2
Stillbirths and neonatal deaths	1.05	1.3

tal. There was the same type of selection in our cases, however, as the potentially more complicated cases were sent to Johns Hopkins Hospital rather than to other smaller hospitals where facilities for handling difficulties might not be so good.

What of other complications? It was difficult to find an exactly comparable group of patients to make a fair statistical comparison. Our series of private cases includes the years 1931 to 1945. Statistics for the Johns Hopkins Hospital in general were not separated into service and private cases before 1937. Also our series contains a lower percentage of premature deliveries than the unselected run of hospital deliveries. Therefore, to make the fairest comparison available under the circumstances, we decided to use the figures for the mature private deliveries for the years 1937-1945 and compare them with the mature deliveries only, in our series. Table IV shows this comparison.

There was only one cesarean section in the induction group, a 30-year-old primipara, who was induced because of mild preeclampsia five days before her expected date of confinement. This induction was done in 1934 before the importance of a favorable cervix had been widely recognized. The cervix in this case was described as 2 cm. long, firm, and closed. Obviously today this would not be considered a favorable cervix for induction. The patient went into labor after a latent period of 2 hours. Secondary uterine inertia developed, and a low cervical cesarean section was performed after 41 hours of labor. The baby weighed 3,750 Gm. and was in good condition. The patient made an uneventful recovery.

There were four neonatal deaths in the series. One was of an infant weighing 990 Gm. The cause of death was prematurity. Rupture of membranes was performed on the mother at 26 weeks for antepartum bleeding. Delivery was spontaneous after a labor of 2 hours and 5 minutes, with a latent period of 10 minutes.

The second was of a baby weighing 4,210 Gm., who died of diaphragmatic hernia. Induction was done as an elective procedure; the cervix was partially effaced and 2 cm. dilated. The latent period was 15 minutes and the labor 1 hour and 30 minutes, with spontaneous delivery.

The third neonatal death was in a case of hydrops fetalis. Induction was done one month before term for acute hydramnios and preeclamptic toxemia. The baby weighed 3,400 Gm. Delivery was by low forceps. Latent period was 1 hour and 55 minutes, labor 8 hours. The cervix was effaced and 3 cm. dilated at the time of rupture of membranes.

The fourth neonatal death was in a 28-year-old Para I. Induction was done 11 days before her expected date of confinement because of a previous excessive size infant. The cervix was effaced and fingertip dilated. After a latent period of 2 hours and a labor of 27 hours and 17 minutes, the baby, weighing 2,180 Gm. was delivered spontaneously and died several hours later. Autopsy showed prematurity, subarachnoid hemorrhage, and coarctation of the aorta.

In the first case the neonatal death was a direct result of treatment of the mother for severe antepartum hemorrhage which required immediate delivery. In the second and third cases there were fetal anomalies and disease incompatible with life. In the fourth case, it was questionable to what extent the prematurity and subarachnoid hemorrhage contributed to death or to what extent coarctation of the aorta was responsible.

One of the pitfalls of induced labor is the accurate estimation of the size of the baby. The expected date of confinement based on the patient's memory of the last menstrual period can be misleading. That this did not turn out to be too much of a problem in this series, however, is shown by the fact that only 3 other babies in the 193 weighed under 2,500 Gm.—their weights were 2,404, 2,470, and 2,480 Gm. respectively. All the babies did well.

In recent years stress has been laid on certain criteria which, if adhered to in the selection of cases, should lessen the incidence of complications. Tew[5] has recommended the following: "The lowermost portion of the head must be at or below the level of the spines, the cervix should be soft and

TABLE V

Comparison of periods 1931-1939 and 1940-1945 according to puerperal morbidity and length of labor.

	Induction Series	
	1931-1939 (percent)	1940-1945 (percent)
Puerperal Morbidity		
Average for the period	10.22	1.9
Patients with labors over 12 hours	14.77	1.9

the cervical canal less than 1 cm. long; the patient must be at or near expected date of confinement."

It was decided to see whether there was any correlation between the incidence of prolonged labors and puerperal infection in this series with the state of the cervix at the time of induction. This proved difficult to do, however. Except in one case which ended in cesarean section, where the cervix was described as long and closed, all the other cervices are described pretty uniformly as "partially effaced, 1 to 2 cm. dilated."

Determination of the favorability of the cervix has been given much more attention since reports have appeared in the literature calling attention to the importance of this condition. We feel that experience over the years has improved the ability to recognize a favorable cervix. It is important to follow the patient regularly with vaginal examinations at many prenatal visits in order to evaluate properly the changes that are taking place in that particular cervix. In this series of 193 cases, 87 were induced from 1931 to 1939, and 106 were done from 1940 to 1945. If more careful selection of the favorable cervix were a factor, prolonged labors and puerperal morbidity should be more frequent in the earlier years. That this is true in our series is shown by Table V.

It is obvious that since the introduction of antibiotics, puerperal morbidity in general would be less in the years 1940-1945 than in the years 1931-1939. This reduction was from 13.71 percent for white patients from 1931-1939 to 7.33 percent from 1940-1945, or less than 2 to 1. In the induction series, however, the reduction in morbidity was from 10.22 percent in the years 1931-1939 to 1.9 percent in the years 1940-1945, or in excess of a 5 to 1 reduction. Since the reduction in morbidity in the latter years of the induction series was greater than would be expected, this would seem to indicate that selection of cases with regard to favorability of the cervix is a factor in lessening complications following induction of labor.

The above figures in puerperal morbidity do not bear out the statement of Dieckmann[1] and others quoted in the first paragraph of this paper: that morbidity is inevitably increased by his procedure.

Prolapsed cord is another frequently mentioned complication of induced labor. There were no instances of prolapsed cord in this series, though no particular attention was paid to the station of the head.

Summary and Conclusion

1. A study has been made of the results of induction of labor by artificial rupture of the membranes in 193 private deliveries.

2. Median length of labor for primigravida was 5.5 hours, for multiparas 3.5 hours. Of the deliveries, 93.2 percent required less time than 12 hours, 69.4 percent less time than 6 hours. Only 1.5 percent of the labors exceeded 24 hours and only 1 percent more than 30 hours.

3. Puerperal morbidity was 6 percent; postpartum hemorrhage rate, 0.5 percent; cesarean section rate, 0.5 percent; stillbirth and neonatal mortality in the mature cases, 1.05 percent. These figures compare favorably with figures for white private patients at Johns Hopkins Hospital during almost comparable years.

4. There were no cases of prolapsed cord in this series.

5. Results can be improved by careful selection of cases for induction as to favorability of the cervix. Repeated vaginal examinations are important in order to evaluate the cervix. There is no increased maternal morbidity apparent from this procedure.

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Psychotic or Delinquent?

CASE REPORTS OF TWENTY-ONE GIRLS TRANSFERRED FROM TRAINING SCHOOL TO STATE HOSPITALS

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In the past 11 years, 21 girls have been committed to Maryland State Hospitals from Montrose Training School for delinquent white girls. The history, problems, and ultimate results of treatment in hospitals and the training school are presented. What have been the diagnostic criteria for transfer? What have been the results?

Of the 21 subjects, one was an epileptic, three were defective delinquents, one was a psychopathic personality, and the rest were, in my opinion, psychotic. The State Hospitals frequently did not agree with my diagnoses, and in many cases made the diagnosis of a primary behavior disorder. This difference sent me to the literature to see how others dealing with adolescents felt about the serious reactions which necessitate hospitalization.

The literature is surprisingly sparse. There are numerous articles on adolescence and its problems, but few about adolescent psychotic reactions. In 1941, Bradley and Bowen[1] had an article published based on the study of 14 out of 138 children admitted to the Emma Pendleton Bradley Home in Providence, Rhode Island. They listed eight cardinal symptoms of schizophrenia in children: seclusiveness, irritability when interrupted, daydreaming, bizarre behavior, diminution of personal interests sufficient to be noted by the casual observer, regression of personal interests, physical inactivity, and sensitivity to criticism or praise. In all later articles, these are quoted and used as criteria for a definite diagnosis of schizophrenia.

Warren,[2] in 1949. noted the scarcity of studies of adolescent mental disturbances. He was concerned with attempts to discover how far adolescence itself is a factor in mental breakdown occurring during this life period. His subjects were the adolescents admitted to the Maudlsey Hospital for a 2-year period; these he divided into psychotic, 19 cases, and non-psychotic, 31 cases. The latter group he subdivided into the psychoneuroses and severe personality disorders or organic disease. In the psychotic group the most frequent diagnosis was schizophrenia. The most persistent factor in etiology seemed to be a disturbance in, or lack of, maternal influence. The symptomatology covered the range of symptoms found in psychiatric illness. The present illness seemed to be more often of gradual onset in the non-psychotic, and of more sudden onset in the psychotic. Adolescent traits were found to color the symptoms in most non-psychotics, and were much less evident in the psychotic.

In a study of emotional disorders at the Bradford Child Guidance Clinic, Edelston,[3] in 1949, discussed the difficulty of diagnosis in early cases and suggested dividing the disorders into maladjustments arising out of personality defects or difficulties of character, and psychologic illnesses of adolescence. In the first class he included (1) real inferiorities of endowment, such as emotional or intellectual dullness or severe emotional immaturity; (2) extreme temperamental variations, such as the grossly introverted character; (3) shy withdrawn characters, with feelings of inadequacy and inferiority, evident internal conflict, and family tensions much in evidence, particularly with one or the other parent. In the second class, psychologic illnesses of adolescents, he included (1) neuroses, mostly anxiety states of varying degrees of severity, sometimes a continuation or recurrence of the obsessional state of early childhood; (2) panic reactions; (3) early schizophrenia.

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SYMPTOMATOLOGY AND FAMILY BACKGROUND IN CASE REPORTS OF 21 GIRLS TRANSFERRED FROM TRAINING SCHOOL TO STATE HOSPITALS

Cardinal Symptoms	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Regression of interests	−	−	−	−	−	−	−	−	−	−	−	−	−	−	−	−	−	−	−	−	−
Physical inactivity	+	−	+	−	+	−	+	−	−	−	−	−	−	−	−	−	+	−	−	−	−
Diminution of interest	+	−	+	−	+	+	+	+	−	−	+	+	−	−	−	+	+	+	−	+	+
Oversensitivity	−	−	−	−	+	+	+	+	+	−	+	+	−	+	−	−	−	+	−	+	+
Daydreaming	+	−	−	+	+	+	+	+	+	−	−	−	+	+	−	−	+	+	+	+	−
Bizarre behavior	+	+	+	−	+	+	−	+	+	−	+	+	−	+	−	−	−	+	−	+	+
Irritability	−	−	+	−	+	−	−	+	+	−	+	+	−	+	−	−	−	−	−	+	+
Seclusiveness	+	−	+	−	+	+	+	+	+	−	−	−	−	−	−	−	+	+	−	+	−
Additional Symptoms																					
Suicidal attempts	−	+	−	+	−	−	+	+	−	−	+	−	−	−	+	−	−	−	−	+	+
Temper tantrums	−	−	−	−	−	+	−	−	+	−	−	+	−	+	−	−	−	−	+	+	+
Resentfulness	−	−	−	−	+	+	−	+	+	−	+	+	−	+	−	−	−	+	−	+	+
Inability to accept reality	−	−	−	−	+	−	−	−	+	−	−	+	−	−	−	−	−	+	−	+	−
Homicidal threats	−	−	−	+	−	−	−	−	−	−	+	+	−	−	−	−	−	+	−	−	−
Family Background																					
Mother dead	−	+	+	+	−	−	−	−	−	−	−	−	−	−	−	−	−	−	−	−	−
Broken home	−	−	−	−	+	+	+	−	+	+	+	+	−	−	−	+	−	+	−	+	+

Wallinga and Bachrach[4] divided the adolescent behavior disorders into psychoses, neuroses, primary behavior disorders, and disorders due to mental defects. In their cases the psychotic group was entirely schizoid or schizophrenic, and the most marked symptoms were withdrawal from normal activities, bizarre manneristic behavior, disorientation, and confusion. They found irritability and seclusiveness in the neuroses as often as in the behavior disorders and in the mentally defective. The primary behavior disorders were characterized by destructiveness, temper tantrums, running away, and suicidal attempts. In the mentally deficient, impulsiveness was the most outstanding characteristic.

While all of these writers emphasized slightly different angles of the problems, there is one thing that seems obvious in their case studies. Among the adolescents requiring hospitalization those who cannot be diagnosed as psychotic outnumber those who can. According to the hospital diagnoses, the same is true in the present group of cases, although at the time of commitment I felt definitely that the patients were psychotic, and, in the majority of cases, schizophrenic.

The symptomatology was variable (See Table). Eight patients made suicidal attempts while at Montrose, three of whom had attempted suicide previous to admission. Suicidal talk occurred in all this group while at Montrose. Seven patients had severe temper tantrums with destructiveness and combativeness; two of these patients were also among the suicidal group. Among the group with serious temper tantrums, two made frequent homicidal threats, and two who did not have the tantrums while at school, also made homicidal threats. Another frequent symptom, not mentioned particularly in other reports, was resentfulness, with inability to accept correction or suggestion. Perhaps this is what Bradley and Bowen meant in their group of sensitive children who could not accept praise or criticism. This was marked in 10 cases. Another finding was inability to accept reality, an insistence on returning to a family unable and unwilling to accept the patient. This occurred in 5 cases.

Of the eight cardinal signs of childhood schizophrenia, all occurred except the regression of interests. Physical inactivity occurred in 5 cases; diminution of interest in 13; oversensitivity in 11; daydreaming to excess in 13; bizarre behavior in 13; irritability in 9; and seclusiveness in 10 cases.

In comparing my diagnoses with the eight points of Bradley and Bowen, I find that in one case which I did not call schizophrenia more than five of their diagnostic symptoms were present and that several cases which I felt were schizophrenic did not actually have more than two or three of the eight symptoms. The State Hospitals are reluctant to label any of the cases schizophrenia unless more typical adult symptoms, including hallucinations and catatonic features, are present, and are apt to label the questionable cases as primary behavior disorders.

Of the 21 patients, my diagnosis in 12 was schizophrenia or the possibility of schizophrenia. Two others I felt were definitely psychotic. The State Hospitals' diagnoses included only two of schizophrenia, catatonic type; one of psychosis with mental deficiency, depressed; one of epilepsy with psychosis; and one of neurosis mixed with hysterical and compulsive aspects. The others were all called "without psychosis."

The differences are more academic than practical. In all cases the State Hospitals felt that although the patients might not be psychotic they needed institutional care and psychiatric help to return to more normal behavior patterns. However, they felt, as I did, that the State Hospitals were not adequately equipped to care for adolescents on their wards with adult patients, and yet that the training school was not able to cope with behavior disorders such as these. Most of the girls, after a period of adjustment in the hospital, were returned home but several of them came back to Montrose and were paroled from there.

The backgrounds of the girls were felt to contribute much to their difficulties in adjustment, and, as others have noted, the etiologic significance of parental loss and broken homes was evident. The mothers of three of the girls were dead (See Table). Eleven other girls came from broken homes, this group including girls whose parents were still together but whose fathers were alcoholic to such an extent that there was constant fighting at home. Thus, 14 had an unstable family background; 8 had been living in foster homes, with relatives, or in institutions, and most of these had shifted their homes many times.

The conclusions from such a study cannot be too definite. This is not a large enough series of cases to give more than suggestions as to the treatment of adolescent mental breakdowns. In these cases it would seem that the most common etiologic factor in adolescent maladjustment is found in disturbed relationships within the family, particularly the broken home, whether from parental death or from separation or divorce. The symptomatology in these cases shows a predominance of severe tantrum-like behavior and inability to accept life situations. Whether this is to be called schizoid, schizophrenic, or primary behavior disorder, is not so important as is what can be done in treatment. That something can be done before this state is reached is evident by the fact that in 11 years it has been necessary to hospitalize only 21 girls out of all the girls who have shown disturbances in behavior serious enough to necessitate commitment to Montrose. Many girls who presented as poor backgrounds as these 21 had some of the same symptoms, but were able to regulate their activities in a more normal way by means of the training school program and psychotherapy. Again, that something can be done in treatment after hospitalization is necessary is evident from the fact that of these 21 girls only 2 are still residents in the State Hospitals. The rest have been discharged improved, usually within a few months after admission. Several were discharged against advice, and some were tried on parole and returned to the hospital several times before final discharge. It is assumed that those who have not returned are making satisfactory adjustments outside institutions.

Case Histories

Case 1. N. McK., aged 18, was first seen June 1936, on her return to Montrose from parole; she was attractive and pleasant, but superficial. She was paroled; returned, June 1937; paroled; returned, June 1938; paroled; returned, January 1939. At this time her behavior was different; she was vague, complained of poor sleep, wanted to stay in her room alone, said, "I think I am sick mentally"; was aloof, expressed depressive thoughts of failure and of guilt, but did not actually appear depressed. She was transferred to Spring Grove State Hospital, February 11, 1939. My diagnosis was: Schizophrenic process; their diagnosis: Psychopathic personality. She improved rapidly in hospital and was returned to Montrose, June 5, 1939; was paroled within a few weeks as she had reached the age of 21. She married but continued to run around, and had an illness suggestive of abortion. In October 1939, she came to Henry Phipps Psychiatric Clinic voluntarily, and was recommitted to Spring Grove. Her behavior this time was argumentative, mischievous, teasing. The diagnosis again was psychopathic personality. She was paroled, December 1939, and discharged in 1940. She has had no further State Hospital admission.

Case 2. B. L., was admitted September 19, 1938; discharged one month later; returned, December 8, 1938. On first admission she seemed to be a normal child, with behavior difficulties, but on return was sullen and resentful, with mood swings. In March 1939, she made an unexpected attempt at suicide. When seen a few days later she was sullen, threatened suicide, talked of smoking marihuana, said she had harmed herself by this and by witnessing perverted sex acts. As it was thought she was a suicidal risk, and that this was an early schizophrenic reaction, she was committed to Springfield, March 9, 1939. Her hospital history noted that she had been a difficult child and that acute behavior disorders had begun after her mother's death. Diagnosis: Primary behavior disorder in an adolescent. She was paroled as improved, August 6, 1939; returned, February 17, 1940; finally discharged from parole as improved, February 26, 1941.

Case 3. E. N., aged 15, mental age 10 years 8 months, I.Q. 71, was admitted to Montrose, August 27, 1938, after failing to adjust in several boarding homes; suspected of sex delinquency. Father was alcoholic, mother dead. Admission impression was: Seri-

ously retarded, unstable girl. She adjusted well until March 1949, when she began to act in a peculiar way and to make suicidal threats. Following an hysterical screaming spell, she settled down to mumbling to herself and refused to respond to questions. She was transferred to Eastern Shore State Hospital, April 12, 1939. Diagnosis: Schizophrenic reaction in a retarded adolescent. Course in hospital is unknown.

Case 4. E. M., aged 14, I.Q. 87, was admitted March 22, 1943, a known prostitute, with history of 12 commitments to the city jail. She presented a different problem. Her father was alcoholic, her mother dead. Placed in a Methodist home for girls, she had run away when 13; had refused to stay with her father; had lived about; had been in constant trouble; and, lying about her age, had been sent to jail rather than to Montrose. When told she was to go to Montrose, she drank nail polish and cut her wrists in the police station, and was destructive in the accident room. On arriving at Montrose, however, she was quiet and during her stay was not violent. On examination she was vague, sullen, made many threats, but was polite and co-operative with the doctor. She escaped from school, but after a week was picked up by the police and returned, showing resentment and boastfulness. She was transferred April 23, 1943, to Springfield, with the notation, "Psychopathic personality; a dangerous person to herself, the school, and the community." At Springfield the diagnosis was: Psychopathic personality; and it was decided to keep her as long as possible. She escaped, August 8, 1943; was discharged, August 9; and returned, April 16, 1946, having taken potassium permanganate by mistake. She had been drinking heavily. She escaped again, June 16, 1947, and has not since been heard of at the hospital.

Case 5. N. C., aged 13, I.Q. 101, was admitted August 4, 1941, because of her persistent running away from boarding homes and the Child Study Home, back to her mother who, although unable to have her at home because of her own nervousness, showed some interest in her. Her parents were separated; her father, a diabetic, contributed to her support. One sister was with the father, one brother with the mother, one brother at the Maryland Training School. Admission impression was: "A girl of average intelligence, unable to accept emotionally the fact that she cannot live in her own home, and unable to adjust to girls her own age." From February 1942, until October 1942, because of her refusal to take part in activities, general unco-operativeness, and difficulties with the girls, she was seen in psychotherapeutic interviews and became more accessible and her behavior improved. From October 1943, to February 1944, she was seen at frequent intervals, because of smiling to herself and having difficulty with others. She improved again and expressed some insight, which was short-lived, but she was paroled, July 1944, to her mother. At home her behavior deteriorated rapidly, she slept all day, ran about all night, resented correction and restriction, was dirty, and refused to help with any housework. She was returned to school, January 1945, and transferred to Springfield within a week. Diagnosis: Schizophrenic reaction, with deterioration in habits; diagnosis at Springfield: Behavior disorder. She made a fine adjustment and was paroled, April 1945, to her father, but was delinquent a year later. She was readmitted, March 1947, in acutely excited state which had required restraint in a general hospital where she was under treatment for an incomplete abortion. The diagnosis at this time: Psychoses with constitutional psychopathic personality. She improved, eloped from hospital, August 1947, while plans for parole were being made, returned to hospital, September 3, 1947, by the Vice Squad which had picked her up in a man's apartment. She was paroled to her father, September 10, 1947, but left his home in February 1948, and has not been heard of since.

Case 6. H. C., aged 14, I.Q. 81, was admitted August 1945 as a runaway. She had had a previous admission for two weeks as state's witness after having been raped. During present admission she accused her father of attempting sex relations with her. The father was alcoholic and abusive, the mother protective. Her sister and brother, who were in regular grades in school, called her dumb. She had temper tantrums and nightmares. When 12 she had been hit by an automobile, with no definite injuries, but she blamed her poor posture on this accident. She had stopped school at 14 and tried working, but was fired because of fights. Admission impression was: Neglected, retarded girl with unfortunate disposition. She made a good adjustment for six weeks, then jumped out of a window to run away, but claimed no memory of the event. Following this, she was afraid and talked of hearing noises and voices. She was transferred to Springfield State Hospital, November 7, 1945, where her behavior was childish, attention-demanding. The diagnosis was: Constitutional psychopathic personality without psychosis, borderline defective. She returned to Montrose, February 7, 1946, talkative and happy; was discharged April 1946. After two months at home she became restless, had temper tantrums, and was generally unmanageable, so she was brought to Phipps Clinic and recommitted to Springfield. On this admission she was argumentative, disturbing, unable to carry out various hospital jobs. In September 1948, she was placed by the hospital in family care, and in June 1949, was returned to her mother. Final diagnosis was: Mental deficiency, borderline, without psychosis, behavior disorder.

Case 7. L. J., aged 18, I.Q. 75, was admitted November 26, 1945, after a suicidal attempt. She had been drinking heavily and keeping late hours. Her story was at variance with facts, including marriage and husband's death. She had completed three years of high school; her parents were divorced and she lived with her father. She was depressed, slow in her reactions, slept and concentrated poorly, bit her nails to the quick, and was preoccupied. Her I.Q. was felt to be lower than her ability. After a few weeks of attempted treatment at Montrose, she was transferred to Springfield State Hospital with the diagnosis: Reactive depression in unstable girl. At Springfield she showed more sullenness, her stories became more exaggerated, and she was belligerent whenever denied a request. She was released, February 21, 1946, on probation to the court, but after being in frequent trouble for fighting, she was readmitted to Springfield, October 1946. Her behavior continued to be difficult and she remained in the hospital, finally having a lobotomy in 1951. Her behavior improved and she was less aggressive, but was still in hospital in May 1951. Diagnosis: Constitutional psychopathic personality, with pathologic sexuality, non-psychotic behavior disorder.

Case 8. B. B., aged 15, I.Q. 75, was admitted September 1946 as a persistent runaway, due she claimed to her desire to be sent to Montrose and to get away from her mother who mistreated her. Parents were hard-working and interested in their children, but quick-tempered and unable to cope with them. Of 12

children, 2 boys were at the boys' training school, a sister had been at Montrose, and another is there now. B. has hearing defect since meningitis at age of four. Admission impression: Neglected, retarded child, in need of training. She made good school adjustment until August 1947, when she talked of suicide and of feeling of being unwanted. Attempts to treat her with sedation, removal from pressure of school assignments, and psychotherapy made little improvement. Following a dramatic dive down the laundry chute, she was transferred to Springfield State Hospital, September 11, 1947. Diagnosis: Schizophrenic reaction in retarded child; serious suicidal risk. The same behavior persisted in hospital. She was taken home against advice, October 1947. Diagnosis: Psychoses with mental deficiency; depressed reaction; condition improved.

CASE 9. J. W., aged 12, I.Q. 78, was admitted September 16, 1943, following discovery by foster mother that she and her brother were indulging in sex play. The brother was kept at home. The father was alcoholic, whereabouts unknown; the mother totally inadequate. J. and brother were in foster home for six years. She had been slow in development, still spoke with a lisp, and was very shy. Initial examination revealed speech defect, probable deafness, poor vision. Initial impression: Retarded, unstable girl. She made a good adjustment for several months, then indulged in a series of upsets and fights, apparently resulting from resentment to training. Following a visit home in 1945, there recurred an episode of dirtiness; then a series of temper tantrums, with periods of good behavior between. She was paroled to a work home, December 1946, did well until June 1947, when she ran away to her mother; returned to school, July 1947; a month later had severe tantrums with amnesia (?); and was transferred to State Hospital, October 1947, for observation with suggestion that temper outbursts might be epileptic equivalent. She made a good adjustment and was paroled, January 1948, but in August 1948, another temper outburst brought her back to hospital. She was paroled September 1949, but in June 1950 ran away and was returned to the hospital. She was paroled again in July and was still doing well in May 1951.

CASE 10. T. M., aged 16, I.Q. 58, was admitted April 1946, with history of running away, late hours, and general promiscuity. The father is alcoholic, will not work; the mother supports children, working as waitress. Admission impression: Defective, neglected girl, in need of training; transfer to institution for the feeble-minded or State Hospital recommended. She was returned home; readmitted, June 1947, with same history, and transferred to State Hospital as defective delinquent, which diagnosis was confirmed. She was paroled, May 1950; readmitted, February 1951. It is expected she will remain permanently as she cannot take care of herself outside of an institution.

CASE 11. P. H., aged 14, was admitted August 1948 as persistent runaway from all of her many homes. Parents had been divorced eight years previously. The father had placed her with various paternal relations, finally allowed her to go to mother and stepfather, but again she ran away after a scolding, feeling her mother did not want her. On admission she was friendly, tearful in talking of home, and ashamed of her one sex experience. Impression: An unstable girl, who has reacted with defiance to confusion in her home life and parental relationship. By December 1948, she had become sullen, was belligerent when corrected, and made suicidal threats. Her attitude improved under psychotherapy for a time, but, in March 1949, she became disturbed, threatening to choke and hurt others or to kill herself, and was transferred to State Hospital. Diagnosis: Psychopathic personality. Course in hospital is unknown.

CASE 12. P. D., aged 13, I.Q. 77, was admitted September 23, 1946, because she refused to go to school, would not obey grandmother with whom she lived, and kept late hours. Mother had deserted, father remarried. She wondered whether father might have murdered her mother. Her school work was poor; she was always in difficulty because of her disposition, and was evasive and shy on examination. Impression: Retarded girl making a good adjustment. In December 1947, she began to get into trouble; was resentful; had temper outbursts; talked to herself during interviews with psychiatrist; expressed feeling of being abused and threatened to harm matron in her cottage. She was transferred to State Hospital in 1948, because of increasing belligerence and paranoid ideas. In State Hospital she led an up and down course, was tried on parole several times, and was finally discharged. Diagnosis: Behavior disorder.

CASE 13. M. W., aged 16, was admitted July 1948, after having run away and having been unmanageable. After being seen in the psychiatric clinic in her town, hospitalization was advised. She gave a history of nail biting and fears, and of promiscuity. She had stopped school after completing the ninth grade. On examination, the striking feature was the push of talk and distractibility, without elation. The talkativeness continued and the content became increasingly confused. She was transferred to State Hospital. Diagnosis: Hypomanic state. There her thinking was described as disorganized, but the diagnosis was: Behavior problem in adolescent, without psychoses. She was paroled, September 1948; returned a year later showing the same symptoms; was discharged against advice, December 1948.

CASE 14. R. Z., aged 12, I.Q. 88, was admitted March 1948, following a running away, with a history of sex delinquency. At school she had been considered queer. The father was a retired U.S. Army Band man; the mother worked; the younger brother was spoiled and retarded, and R. was jealous of him. She was healthy, but nearsighted and wore thick glasses. On examination she was sullen, sorry for herself, but able to smile at her own inconsistencies. Initial impression: A chronically unhappy, daydreaming girl, who resisted attempts to help her; probably an early schizophrenic reaction. With psychiatric help she was becoming fairly adjusted when her family persuaded the court to release her. She returned to school, October 1948, talkative, elated, full of giggles and wild tales of her adventures; was transferred to State Hospital for study, November 17, 1948; paroled to her mother, December 1948; returned to hospital, August 1949, with record of stealing and prostitution. She had been married, had received antiluetic treatment, and was pregnant. She was placed in a foster home until the birth of her child, March 1950, and then returned to her parents, keeping the baby with her.

CASE 15. D. R., aged 16, was admitted January 1949, in upset state. On the night of admission she made a suicidal attempt; because of this act, depressive attitudes, and continued suicidal talk, she was transferred to State Hospital the following day. She made a fair adjustment in hospital, but was unable to remain long at any task. Diagnosis: Neurosis, mixed with hysteric and compulsive aspects. She was discharged, June

1949, against advice. In April 1951, she called asking to do volunteer work at the hospital as she could not hold a full time job. She has since been doing volunteer work successfully. A younger sister is now at Montrose and doing well, but has a very difficult disposition.

CASE 16. V. W., aged 18, I.Q. 49, was admitted July 1949, with a history of running around the streets. The father was alcoholic; the mother's whereabouts unknown. She and her stepmother were unable to get along. She was transferred to State Hospital as a defective delinquent. Their diagnosis: Mental deficiency, without psychoses. She did well in hospital and was discharged to live with grandmother, March 1950.

CASE 17. F. M., aged 15, was admitted September 1949, after running away from home, taking money, and spending time in a Baltimore hotel. Finally she went to the probation officer who had helped her previously, when she broke a neighbor's window to test out a school discussion of crime and punishment. No other peculiar or delinquent behavior had been reported at school; the family reported temper tantrums and unusual care of her possessions. Both parents were interested in the children, but neighbors reported the mother as being moody. Younger siblings had been no problem before this episode, but the younger sister, later admitted to Montrose, was a difficult, rigid girl. On admission, F. M. was withdrawn, would not talk, would not eat, would stand and stare or lie on her bed. Examination revealed severe blocking in her thinking. The impression was: A sick rather than a delinquent girl; probably schizophrenic. She was transferred to State Hospital, September 29, 1949, where the same behavior persisted for a few days and then improvement was noted. She was taken home against advice, but returned the next day on court order. After being treated with insulin shock, she improved and was paroled, March 1950. Diagnosis: Schizophrenia, catatonic type.

CASE 18. M. M., aged 16, I.Q. 69, was admitted August 1948, after failing to adjust in several foster homes and after the school reported that she was a disturbing factor because of sex talk and behavior. The parents were separated; both were drinkers and fighters; the mother was serving time for neglecting the children. M. M. made the tenth grade in school and earned money helping in the school cafeteria. On admission she was thin, tense, and jerky in speech and movements. Impression: Retarded, unstable girl, who had reacted to the insecurity of her environment with sex delinquency. She did well until December 1949, when peculiar behavior developed: senseless giggling, burning her face with scalding water, hand washing and talking of washing away her sins, of hearing voices. This was thought to be schizophrenic panic and attempts to ease tension with sedatives and psychotherapy were made. When she did not improve, she was transferred to the State Hospital, January 1950. Diagnosis: Schizophrenic reaction, catatonic type, in a borderline defective. Treated with insulin subshock therapy and psychotherapy, she improved and was paroled, December 1950, to her father. A younger sister is now at Montrose.

CASE 19. G. B., aged 13, too retarded to have attended school, married, was admitted October 1949, after being picked up with another girl near Camp Meade. The father had deserted, the mother remarried, and the stepfather supported the family. There was a questionable history of epilepsy. Examination revealed a tall, thin girl, smiling easily as she described her unhappiness. Plans for her transfer to the school for feeble-minded were being made when she became involved in a violent episode and it seemed wiser to send her to an adult institution. She was transferred to State Hospital, March 1950, as a defective delinquent. Diagnosis: Mental deficiency, with psychoses, behavior problem. She was discharged, April 1950, to her mother's care.

CASE 20. D. M., aged 15, I. Q. 95, was admitted January 1951, after running away from her aunt's home, where she lived because of her mother's illness at the time of her birth. There had recently been trouble over school attendance. The father, who was meek and submissive, had contributed to her support. The mother, a peculiar person, carrying with her a statement proving her sanity, was demanding and always interfering. In view of the girl's good behavior, shame over her running away, and good previous record, probation at home with the aunt was recommended and carried out. She was readmitted, March 1951, after running away again. This time she was depressed, made a suicidal gesture, broke up furniture in her room; good behavior alternated with bizarre screaming spells. On one occasion she ran away, and cried hysterically on being found. She showed more rigidity and a refusal to accept reality, suggesting paranoid schizophrenic reaction. Following the screaming spell she was transferred to State Hospital, April 6, 1951. There her behavior was good, she was co-operative and in good contact with everyone. She returned to Montrose, May 6, 1951, with diagnosis of: Behavior problem, no psychoses. Back at Montrose, her bizarre behavior, screaming spells, rigidity, and refusal to accept reality continued.

CASE 21. E. P., aged 14, was admitted June 1949, because she would not listen to her father for whom she kept house, and because she fought with children in school, in one instance with a knife in her hand. Her parents were separated and both had remarried; the father had separated from his second wife. E. P. gave a history of nail biting, of temper tantrums and spasms, and had been in a special class in school. Initial impression: Retarded, neglected girl. In November 1950, she began to have spells at night which ceased under phenobarbital therapy, but she became increasingly resentful and got into fights. In February, she cut her wrists during a tantrum, apparently not with any suicidal intent. Several more severe tantrums and screaming spells resisted heavy sedation and she was transferred to State Hospital, April 1951. Diagnosis: Epilepsy. She was discharged, against advice, to her father's care.

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Common Feeding Problems in Children

Mary L. Hayleck, M.D.

IN ANY MODERN APPROACH to the feeding problems of the healthy infant and child, we must consider several factors. The first factor, naturally, is the nutritional; the second, the mechanical and developmental; the third, the emotional. All of these aspects influence the feeding pattern of the child as an individual, or each may be of special importance to the problems of any given case.

During this century the extensive study of nutrition in its many aspects has introduced newer and more valuable changes affecting the feeding of infants than in almost any other phase of dietetics. Through modern publishing methods these new ideas have spread to the public with amazing facility, and today most mothers, through their own reading or public health education, are fairly well informed concerning nutritional fundamentals.

In this age of gadgets and quantity production, we are offered a variety of mechanics which assist or entice the child to eat. Commercially prepared foods adapted to the needs of the infant have been a great boon to parents. Although there continues to be a constant need for parent education concerning pediatric nutrition, the physician's most frequent problems lie in the realm of the emotional. These demand the most time-consuming and patient help of the physician.

Let us first consider the troubles of the small infant. He has been initiated into life by being rudely thrust into a cold, energy-consuming world where he must seek for himself and consume in himself sources of energy which until lately flowed directly into his blood stream. It is not strange, therefore, that in many infants a disturbed period of adjustment to breast or artificial feeding may occur after birth. This may be characterized by crying, colic, or vomiting despite different types of feeding. Days or weeks may be necessary to eliminate the symptoms. It is interesting to note that a difficult period of this nature seems more frequent with first babies and may be related to lack of experience, insecurity, and awkwardness of the new mother which is reflected in the behavior of the baby. Of course, repeated physical examination helps to rule out physical causes for such behavior and reassures the tense and tired parent. Demand feeding, especially with breast-fed infants where caloric intake cannot be regulated, has relieved some of the trouble during this period. Most infants soon establish a feeding pattern for themselves. The most satisfactory plan for both mother and child is modified demand feeding which employs a schedule allowing meals at frequent intervals when the child is hungry and at longer intervals when he is satisfied or asleep.

Colic, which is more a symptom complex than a disease, is most common during the early weeks of life. It is characterized by crying, drawing the legs up on the abdomen, passage of flatus, and every possible evidence of discomfort which the infant can give. These symptoms may arise from improper or inadequate feeding, intestinal or renal disease, or functional causes. If colic persists in the absence of abnormal physical findings or abnormal bowel habits, it may be necessary to seek more remote physical causes such as urinary tract or neurologic abnormalities. Nutritional status in respect to caloric requirements and protein-carbohydrate balance must be carefully checked and the most satisfactory formula established. Lack of the sense of security of the mother resulting in awkward and fearful handling of the infant may contribute to the situation but may be overcome with experience and reassurance.

The introduction of new types of foods may be difficult. It is most important to realize that just as the child's individual ability to sit up or walk varies in time of development, so may vary his ability to manage the complex physical mechanism of ingesting and swallowing increasingly more difficult foods. Each child must proceed at his own rate and may have to be taught over a period of time how to take the new food. Repeated, patient attempts are often necessary to accomplish this end. Most infants may be given puréed foods in increasing quantity and variety at the age of

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several weeks to three months. Rejected foods should never be forced but occasionally repeated so that a liking for them may be acquired. Later, at eight to ten months, chopped foods are introduced in a similar fashion. The secret of managing these stages is to teach the mother that the infant learns to eat gradually as in learning other skills and that patience and persistence on her part are essential.

Weaning from breast or bottle requires these same virtues and for the same reasons; in addition there is the psychologic need of the infant to suck. Some infants begin to reject the nipple at an early age and thus indicate a readiness for weaning. In those who do not show signs of weaning themselves gradually, more frequent use of the cup offering milk must be made so that the infant learns to associate milk with other things than the bottle. When cup drinking is established there is no mechanical need for further nursing. Other outlets for the sucking need, such as finger-sucking, which is normal in infants, or the pacifier, may be allowed if the infant craves sucking. Healthy infants may be successfully weaned between the ages of eight and fourteen months.

Self-feeding begins automatically in most infants if the parent will accept and allow it. The common expression that fingers were made before forks is most appropriate at this stage. When the baby begins to try to feed himself, he will use his fingers first. He should be permitted and encouraged to do so. Only by experience in using his hands can he become proficient in handling food and implements. The physician can help the parent to understand that mechanical practice is essential and that the child should learn to feed himself even though he makes a mess in so doing and seems to play with food more than he eats it.

Vomiting of food may occur in any age group but it is most prevalent in infants and youngsters. Vomiting in a persistent fashion demands elimination of any possible physical cause. When this has been ruled out the mechanisms of feeding and the possible emôtional factors must be investigated and discussed with the parent. Infantile vomiting is frequently the result of distasteful food or overfeeding. When dislike for a food is evidenced, that food should be discontinued for a while. Overfeeding is the fault of the overconscientious or overanxious parent who is determined to urge all the food the doctor ordered or to have a child as large as the one next door, or who unconsciously makes overfeeding of the child an outlet for other worries and anxieties. The physician can usually recognize and improve this problem by friendly and patient discussion with the confused adult.

Thus the difficulties of infancy merge into those of early childhood. The period between two to four years brings to the pediatrician many complaints about feeding. It has been estimated that one quarter of all children are afflicted with some feeding difficulty. The most common complaint is that of poor appetite. Fortunately this problem usually arises from the parent's lack of understanding of the small child's nutritional needs rather than from any pathologic condition. Most mothers are used to a large appetite in the rapidly growing infant and, with increasing growth, expect a proportionate food intake. They are simply unaware of the decrease in proportionate growth and comparative diminishing caloric needs. We can be most helpful by preparing the way for this normal change by teaching the parent, before the child's appetite fails, that during the first year the child must triple the size of the body, but that in the second and third years only a small proportion of growth is added. Consequently less material is needed for building. If careful inquiry reveals any specific foods lacking in the diet accepted by the child, certain food factors such as protein, calcium, or iron may be added medicinally in some appetizing preparation. Vitamin B complex, which usually stimulates a flagging appetite, may be added to other vitamins that are prescribed. These medications also help to make the parent feel she is doing something to treat the problem. Apparent lack of appetite is often the child's unconscious means of obtaining the parental attention he so desires and may continue as long as he is allowed to enjoy mother's spoon feeding and coaxing.

Another common complaint is that the child does not drink a quart of milk daily. Again the mother must be advised that one and a half pints to a quart of milk, including milk used on cereal, or in the preparation of soups or desserts is adequate for the small child and that, temporarily, less intake is not harmful, especially when other protein foods and green vegetables are being accepted. It has been demonstrated by the work of Dr. Clara Davis that, over a period of time, children with free choice of diet will balance their nutritional intake amazingly well.

During the years after the child has learned to feed himself, social factors may present difficulties. Many parents, especially fathers who come home tired to the evening meal, are not a little annoyed and disgusted by the messy and sporadic eating habits of their offspring. Meal-

times become periods of quarreling, nagging frustation, lost tempers, and tears. When emotional scenes of this sort arise, it is more satisfactory for the whole family if the small child be fed before the adult meal is served. Since the child must learn acceptable habits and learns only through observation and experience, he should be allowed occasional visits to the adult table with increasing frequency as he improves in handling his own feeding in a smoother fashion. No little child should be expected to sit at the table throughout the duration of an adult meal. It is preferable to excuse him from the table as soon as he is no longer interested in eating. Every possible effort should be made to make mealtimes pleasant and restful for everyone concerned. The constant battles between parent and child over what and how much must be eaten are painfully frustrating to both and serve to establish poor mealtime associations and habits in the developing personality.

The older child has fewer problems about food than the toddler and these are more likely to be of an emotional nature. Increased growth and physical activity in the school set usually create increased appetite and mother is more likely to worry about how to fill junior's hollow legs than about his loss of appetite. Children, like adults, have an individual range of appetite both for quantity and variety of food and these tastes should be respected. Food fads and fancies are usually learned in the home. However, unpleasant ideas associated with certain foods may make them distasteful. If older children are taught to taste each food served at the table but never forced to eat what is unpleasant to them, they gradually learn to like many foods. Forcing produces the opposite result.

In school age children, loss of appetite may indicate some illness which should be sought but is more likely caused by emotional factors. Any strong emotion, whether pleasant or unpleasant, may produce physiologic changes which in turn produce lack of interest in food, nausea, and constipation. If such a state does not resolve itself in a reasonable time after excitement or grief or other upsetting emotion, psychiatric help is advisable.

General hygiene plays a real part in the feeding habits of the growing individual. Adequate rest, normal exercise, family habits, regularity of meals, and parental tensions must all be considered in any discussion of the child's problems. In many cases a readjustment of these factors will serve to improve the eating problem.

Overeating and obesity are not limited to the adult and have the same basic causes in childhood. These abnormalities may result from psychic tension in the mother resulting in a need to feed her child beyond his normal requirements. When this is true it may be extremely difficult to help the youngster because it is the parent who needs help first. However, with patience and repeated discussion, which may serve to unveil the real troubles in the parent's mind, help may be possible. As in the obese adult, overeating is usually a subconscious attempt to compensate for some frustration. Most frequently it is the result of the need for affection and love from the parents or more satisfaction in the home relationships. Because life situations producing such disturbances are complex, ordinary simple psychiatry of the everyday office variety may not be adequate and expert help may be needed.

Vomiting, refusal to eat, or the inability to eat and swallow in spite of hunger in a physically well child indicates deep emotional disturbances. Patients with symptoms such as these require psychiatric aid.

Therefore, in managing the frequent cases of feeding complaints in any age of childhood the physician has several responsibilities. First, he must exclude physical causes of the presenting symptoms, then he must educate the parents as to the nutritional and developmental needs of the child in its present stage, and third, he must try to evaluate and correct the psychic components in the situation. With co-operation and loving patience on the part of the parent, and interest and friendly patience on the part of the physician, much can be accomplished in solving the feeding problems of the healthy child.

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Brucellosis

THE WORK OF M. RUIZ CASTANEDA, M.D. AND THE MEDICAL RESEARCH INSTITUTE, MEXICO CITY, D. F.

Lydia Allen DeVilbiss, M.D.

ALTHOUGH Dr. M. Ruiz Castaneda came into brucellosis research by accident, he was well equipped for the task. After graduating in medicine at the University of Mexico, he studied at the University of Paris. From Paris he went to Harvard to engage in research. Associated with Dr. Hans Zissner, the two scientists did the fundamental research which helped pave the way to the control of typhus.

In 1936 Dr. Castaneda returned to Mexico City to continue his work on typhus. He was surprised to find a considerable number of cases of brucellosis confused with typhus or typhoid. These findings decided him to remain as director of medical research of the Hospital General. Later, the National Medical Research Institute was established by Presidential decree and the institute, with its staff of 40 people, is supported by appropriations made by the Government of Mexico, augmented by gifts. This institute is now one of 12 such research institutes affiliated with World Health Organization, United Nations, and Dr. Castaneda is a member of the Brucellosis Panel of Experts. The Government of Mexico has decorated him as one of their most distinguished scientists.

The original work on brucellosis at the National Medical Research Institute includes the spot test, surface fixation test, simplified method of blood culture, and vaccine known as MBP—the name formed from the initials of *Br. melitensis, Br. bovine,* and *Br. porcine (suis)*.

These achievements are not as well known in the United States as they are in Latin American countries. Scientific reports have been published in Spanish language medical journals, and in English language journals: *Public Health and Tropical Medicine; Proceedings of the Society of Experimental Biology & Medicine, Annual Review of Microbiology,* and in bulletins of the World Health Organization.

Brucellosis is considered a prevalent disease in the Republic of Mexico. The chief type encountered, estimated at 98 percent of all cases, is the *Br. melitensis. Br. melitensis* and *Br. porcine (suis)* commonly result in a more severe form of the disease, but critical and even fatal cases have been caused by *Br. abortus.*[1]

Since the three species of Brucella organisms belong to the same genera, one organism or a combination of two or all three, as circumstances seem to warrant, have been used in the production of vaccines. The discovery of cross-infection in animals, i.e., that cattle may be infected with *Br. melitensis* or *Br. suis,* and swine by the *Br. abortus,* suggests the possibility of error in diagnosis in humans.[2] Thus, the use of all three organisms in the production of vaccines seems logical.

VACCINES

Vaccines prepared from heat or chemically killed whole organisms have been used largely to stimulate antibodies. But even a high antibody production is not sufficient to eradicate Brucella organisms from the patient. On the contrary, repeated inoculations with these vaccines may result in an increase of hypersensitivity on further contact with the organisms. Better known as *bacterial allergy,* hypersensitivity is one of several troublesome manifestations which occur during vaccine treatment of active chronic brucellosis.[3]

In the production of MBP vaccine the three species of Brucella — *Br. melitensis,* goat; *Br. abortus,* bovine; and *Br. porcine (suis)* swine, organisms are ground together—and are fractionized. Certain fractions soluble in chloroform or ether are disregarded. Those fractions which are soluble in water are capable of stimulating allergic reactions such as the positive skin tests, and, like

This information on methods of diagnosis and treatment of brucellosis at the National Medical Research Institute was obtained from a study of reprints and interviews with Dr. Castaneda; by inspection of laboratory procedures and animal experimentation; by visits to patients; and by review of records in the brucellosis clinic and wards of the Hospital General, March and April 1952—L. A. DeV.

the killed whole organisms vaccines, they can also produce antibodies which favor sensitivity.

The water soluble fractions contain proteins, polysaccharides, and substances of an indefinite composition referred to as Fraction S. When these water soluble fractions are highly diluted, the proteins and polysaccharides are practically eliminated. The remaining substances produce results similar to that of haptens. They can stimulate immunologic reactions but they cannot of themselves stimulate antibodies.[4]

The highly diluted water soluble substances are the active agent of MBP. Through studies made at the institute it has been demonstrated that MBP does not cause sensitivity or other complications often encountered with the use of killed whole organisms vaccines.[5]

At the institute MBP vaccine is used exclusively in skin tests and as a desensitizing agent in subacute and in active chronic brucellosis by Dr. Castaneda. He employs antibiotics in the treatment of the acute, and in some cases of the subacute, brucellosis with excellent results. Antibiotics in the active chronic form will relieve symptoms temporarily and thus give the appearance of a remission. For active chronic brucellosis, he relies on vaccine as the most effective method of treatment.

Case Report

The following case was seen in the brucellosis ward of the Hospital General—and illustrates the value of MBP vaccine.

Young Mexican female, duration of illness three years, was brought to the hospital on a stretcher acutely ill with complaints of fever, copious sweating, and severe joint pains.

Previous treatment: following positive skin test for brucellosis the patient had been given increasing doses of vaccine, heat-killed whole organisms, the species and dosage unknown.

Inspection: on patient's forearms were numerous reddish-brown patches 1 to 2 cm. in diameter, comparable to fading positive skin test reactions. What had been done in effect had been to increase the sensitivity with each succeeding dose.

Laboratory reports: agglutination titer 160, skin test positive, blood culture negative.

Diagnosis: active chronic brucellosis.

After four weeks of hospital bed rest and treatment with MBP vaccine, the patient was ambulatory and ready to be dismissed. Treatment twice weekly for a total of 10 weeks to be continued by local physician, and patient to be kept under observation for several years.

Laboratory Procedures

In some cases of brucellosis, the MBP vaccine skin test and the blood culture may both be positive. In others, the blood culture may be positive and the skin test negative. Often after a relatively short period of treatment with MBP vaccine the skin test may be positive and the blood culture negative. Again, during the weeks of treatment, or during the period of observation following treatment, the two tests may reverse their status. No rules can be formulated for these phenomena.

In some cases a positive skin test may be the only laboratory evidence of active chronic brucellosis elicited. However, to be accepted as a diagnosis of brucellosis, the skin test should exhibit an intensity of clinical significance and the patient should manifest clinical symptoms of the disease. Usually the patient is ill.

Skin Test

MBP vaccine 0.10 cc. is given intradermally in the forearm. The reaction is observed at 24 and again at 48 hours. The skin test reaction wheal may not be larger than 2 cm., which is the usual reaction, or it may be from 4 to 8 cm. In the severely Brucella sensitized individual the skin test may be so intense that a patient occasionally develops lymphangitis; more rarely a necrosis.

In active chronic brucellosis the skin test more often is intensely positive than weak or negative. The reaction wheal will frequently persist after 48 hours. A positive skin test reaction with MBP vaccine that fades after 24 hours is not accepted as evidence of brucellosis, in the absence of other laboratory reports such as a positive blood culture.

A negative skin test may be found in bacteremic cases at any stage of the disease, whether acute or chronic. A negative skin test, using MBP, may be found also in cases of acute brucellosis for the reason the patient has not yet developed sufficient sensitivity. After one month or more duration of the disease, the skin test is usually positive.

In the acute case of suspected brucellosis, a skin test made with killed whole organisms vaccine may be positive or negative; but it can also produce an increased sensitivity and an acute exacerbation of the disease.

Blood Culture

An effective method for isolation of Brucella organisms from the blood makes possible an estimate of viable organisms per cubic centimeter and affords an approximate criterion of the intensity of the bacteremia.[6]

The simplified Castaneda method employs a culture media of agar (Bacto-tryptose) slants to which is added a small amount of tryptose broth. Bottles are tipped on their sides every 48 hours for 20 days so that the agar slants are re-inoculated by the liquid portion. This is equivalent to 10 transfers by other methods. By the use of agar slants in tightly closed bottles, the danger of infection for technicians is virtually eliminated.[7]

Spot Test

The spot test[8] is a rapid agglutination test which can be made at the bedside of a patient suspected of Brucella infection. It will usually confirm the presence of infection, whether acute or subacute, and in many cases, the active chronic form.

The antigen for this diagnostic test is prepared from *Br. abortus,* stained with methylene blue. With a wire loop, one drop of the antigen is placed on a slide, a drop of whole blood is added—a finger prick is sufficient—or citrated blood may be used. The slide is slowly and gently revolved so that the free liquid gravitates to the bottom of the spot. This revolution is continued until the specific action takes place, usually within three minutes.

In a positive reaction the red cells will be seen forming a center of the spot, surrounded by a blue ring. When held to the light an intensive spot test reaction will be seen to resemble a stained glass window.

In a negative reaction the heavier red blood cells will gravitate to the bottom of the spot; and as the slide is slowly revolved, they will form a thin reddish line around the periphery.

Surface Fixation Test

The surface fixation test[9] is an immunologic reaction. It is a confirmatory test highly regarded as having a specific reaction to Brucella infection. The test is simple to perform but requires some laboratory equipment.

Brucella antigen, stained deep violet, is printed as a dot on filter paper. The dried spots will keep well and be ready for use for several months. The blood serum is placed over the dot and the filter paper suspended over isotonic saline solution. A mixture of the Brucella antigen and normal blood serum will be washed up by capillary attraction. But if the mixture contains blood serum from a case of brucellosis, the dot will remain fixed.

The test should be controlled with known positive and known negative blood sera in order to compare reaction of the unknown. For an individual test in a case of suspected brucellosis, it is helpful to place the controls on either side of the unknown. The positive control (brucellosis) remains as a deep violet dot; the negative is washed up. The unknown is judged, degrees 1, 2, 3, 4, according to the migration length of the washed-up column.

Treatment

MBP vaccine is always given subcutaneously. Following the intradermal skin test of 0.10 cc., subsequent doses are increased by 0.10 cc. until the final dose of 2 cc. is reached. Given twice weekly the customary treatment is usually concluded in 10 weeks. The patient with severe infection and high tolerance may safely be given larger doses. For one with low tolerance the increase in dosage may be smaller.

After treatment, the patient is kept under observation for at least two years, longer if possible. If at any time during the period of observation the skin test is negative, nothing is gained by repeating MBP. But if the patient begins to exhibit clinical symptoms of a recurrence, and the skin test is markedly positive, the 10 weeks' treatment is then repeated.

Of the more than 6,000 cases treated with MBP in the clinic and brucellosis wards of the Hospital General, records indicate that not more than 30 percent returned for re-treatment.

Summary

1. Original work on brucellosis at the National Medical Research Institute includes the spot test, the surface fixation test, the simplified method of blood culture, and the vaccine known as MBP. In production of MBP the three species—*Br. melitensis, Br. bovine,* and *Br. porcine*—are ground together and fractionized.
2. Brucellosis is prevalent in Mexico, the chief type being *Br. melitensis.*
3. Of more than 6,000 cases of brucellosis treated with MBP at the institute, not more than 30 percent have returned for re-treatment.
4. Antibiotics used in treatment of acute and subacute brucellosis have given excellent results. For active chronic brucellosis, MBP is the most effective treatment.

MBP vaccine and antigen for experimental tests may be procured, without cost, upon request to Dr. M. Ruiz Castaneda, Director, Medical Research Institute, Hospital General, Mexico City, D.F.

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Brachial Palsy Following Gynecologic Surgery

CASE REPORT

Eleanor Scott, M.D.

THIS CASE IS presented in order to call attention to an unfortunate complication of surgery which should be preventable, but which is continuing to occur, apparently more frequently in recent years since the introduction of curare as an anesthetic agent.

The patient, L. B., a 32-year-old married female, entered the hospital on the gynecologic service with multiple myomas of the uterus. On September 26, supravaginal hysterectomy was performed and numerous adhesions caused by a previous pelvic inflammatory disease were freed. The anesthetic used was a combination of Pentothal® Sodium, curare, cyclopropane, and ether. The Trendelenburg position was maintained during the greater part of the operation. One shoulder brace only was used, on the left side. The patient received 1500 cc. of blood during the operation. The first 1000 cc. were given in the right arm (on the side not supported by the shoulder brace), which was abducted on an arm board during the entire operation. Forty-five minutes before the end of the operation the patient's blood pressure began to drop slightly, and since it was noted that the blood was running very slowly into the right arm it seemed advisable to give the last 500 cc. in the left arm, which had been, until this time, at the patient's side. The left arm was then abducted and placed on an arm board, and the blood was administered. The patient left the operating room in excellent general condition.

When she awakened from the anesthetic, however, she noticed at once that she could not move her left arm or hand. Neurosurgical consultation was obtained, and the following note was made:

"There is analgesia over an area corresponding to C5 and C6. There is complete paralysis of the biceps, and partial paralysis of the radial and median nerve. Ulnar function is good. *Impression:* Plexus palsy (lower) from pressure. If function does not return in three months, neurological surgery must be considered."

The patient's wrist was supported in extension by a splint, and she was referred to the University Hospital neurosurgical clinic. The note on her first visit there, on October 10, reads as follows:

"Postoperative paralysis, upper extremity. No muscular atrophy. Flaccid paralysis. Some ulnar sensation and possible ulnar use (adduction and flexion of little finger) remain. The radial pulse is palpable on the affected side." Physiotherapy (galvanic current to affected part) and return to neurosurgical clinic were advised.

The next note on her chart, dated November 15, reads: "Hand improved considerably. Elbow action almost nil, though with hand in flexion and forearm in pronation the brachialis holds the weight of the forearm, but cannot initiate flexion. Advise removal of plastic splint and observe effect in two weeks."

On November 21, when the patient was seen again in the neurosurgical clinic, the following note was made: "Reflexes markedly diminished in left arm. Sensation is present. Weakness in pronation and supination. Patient feels as if paralysis is improving. To continue physiotherapy and return in two months."

DISCUSSION

In reviewing the literature on postoperative brachial plexus paralysis occurring during anesthesia, I found that there were a great many articles on this subject written in the 1890's and early 1900's. This was in the early days of deep surgical anesthesia. The paralysis was at first considered to be a toxic manifestation of the chloroform or ether used, but soon the true nature of the condition became apparent, and it was recognized as being due to pressure on or stretching of the brachial plexus occasioned by unphysiologic positions of the deeply relaxed patient on the operating table. Halstead[1] wrote an editorial on the subject in 1908, summarizing the literature up to that time, calling attention to the syndrome, and emphasizing its true nature and preventability. There were few articles after this, until recently, when interest seems to have been revived in the subject. Recent authors are all of the impression that this condition is occurring more frequently. They attribute this to the increasing use of curare, as, with the additional loss of muscle tonus, misplaced shoulder braces are more likely to compress the nerve trunks of the plexus.

In 1942, Clausen[2] reported a series of nine cases. He prefaced his article by saying:

"Preventable injuries to the unconscious patient upon the operating table are, fortunately, infrequent though they occur more often than might be suspected; reports of such injuries are likely to be suppressed because of medicolegal complications, and many of the younger surgeons are entirely unaware of the possibility of such an occurrence. Some of those who do know of it have learned by the bitter experience of obtaining a perfect operative result only to have the patient disabled because of mishandling during her unconsciousness . . . "

Clausen[2] feels that the anatomic factors involved are shown to be lateral deviation and hyperextension of the head, the first rib, the clavicle, the arch formed by the coracoid process of the scapula and the tendon of the pectoralis muscle, and the axillary process of the head of the humerus.

Ewing[3] reported five cases in 1950. It is his impression, to quote, "both from discreet inquiry and from the frank admissions of surgeons and anesthetists elsewhere that they (these brachial plexus

lesions) have been increasingly frequent in recent years." He and others feel that one factor responsible for this increase is the more frequent use of curare which is attended by deeper relaxation than were the previously used anesthetic agents.

He does not feel that direct pressure of even the unpadded shoulder rests on the nerve trunks is a significant factor. He feels that the mechanism is rather a stretching of the brachial plexus. He says that: "Quite the most vulnerable position (in our view) is that of a Trendelenburg tilt combined with abduction at the shoulder . . . The tendency of the head-down tilt position to cause forcible depression of the shoulder girdle will have the effect of rendering still more evident the prominence formed by the head of the humerus. Moreover, in the Trendelenburg position we not only have abduction but we have abduction with a shoulder girdle which cannot readily rotate, so the acromion acts as a fulcrum pushing the humeral head still further down in the axilla . . ."

Ewing did an ingenious piece of research to illustrate this mechanism. He dissected out the brachial plexus on a cadaver, outlined the nerves by attaching a wire to them with Michel clips, then made roentgenograms showing the relative position of the nerves to the head of the humerus with the arm at the side, in abduction, and in abduction with weight applied to the acromion. These diagrams give an excellent explanation of what may have happened to our case, because, while the right arm was abducted for a much greater period of time, it received no injury. The left arm was abducted a relatively short period of time, but was on the side of the shoulder brace and injury occurred.

Of course, injury is not always produced by this set of circumstances. It is possible for the nerve to slip up across the head of the humerus and thus avoid pressure.

It must not be thought that the Trendelenburg position is the only offender in these cases, however, although it is the most frequent one. Kiloh,[4] in 1950, reports four cases occurring following cholecystectomy with the use of a "gallbladder rest." All these patients had abduction of one or both arms and all were given curare. Cases have also been reported following thoracic surgery in which the arms were extended over the head.

Agreement is pretty general among the authors writing on this subject that the following rules for prevention, as summarized by Clausen,[2] should be observed:

"a. With the patient in the Trendelenburg position and the shoulder depressed, the arm should be left at the patient's side." If necessary to give an infusion, a needle or cannula with a generous length of tubing should be inserted preferably into the dorsal aspect of the wrist or forearm before the operation begins so that the arm can be safely folded across the chest or kept down at the side. Ewing[3] goes further and says that even without Trendelenburg the arm should never be secured in extension to a single, or worse still a double, arm board.

"b. When the arm is abducted, the head and neck must be held in neutral position or adducted.

"c. The arm should never be abducted beyond ninety degrees under any circumstances.

"d. The arms must not be abducted and extended above the head when the patient is in the supine or the prone position.

"e. Shoulder braces must be adjusted before the Trendelenburg position is assumed; they should be well padded and adjustable in height as well as in width.

"f. Wide separation of the head and shoulders must be avoided.

"g. Movements of an anesthetized patient must be attended by adequate personnel."

Clausen further states that: "The possibility of this unfortunate complication must be kept in mind by every member of the operating room staff."

I feel that the reason cases do occur in spite of the fact that the etiologic basis has been known for many years is the fact that the preventive measures present many practical difficulties. It is necessary to have the patient in the Trendelenburg position in order to operate efficiently in the pelvis. In the Trendelenburg position it is necessary that some device be used to hold the patient on the table; this device is shoulder braces. Rarely is a major operation performed today without an intravenous infusion, either for anesthetic purposes or as a supportive measure. If the arm is abducted at less than a right angle, there is no room for the operator or his assistants at the table. If the arm is hidden under the drapes at the patient's side or across her chest, it is inaccessible when adjustment is required if the fluids fail to flow satisfactorily. Nevertheless, if attention is called frequently enough to this syndrome, perhaps someone will be able to find a practical solution.

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Woman's Medical Society of Maryland

THE HISTORY OF BRANCH THREE,

P.S. Bourdeau-Sisco, M.D.

THE ORGANIZATION of the Woman's Medical Society of Maryland was inspired by the vision of Dr. Flora Pollack and myself. I had already assisted in the formation of a monthly medical gathering in Michigan, and had later helped in organizing Branch One of the American Medical Women's Association in the District of Columbia. Dr. Pollack had long felt the need of such an organization in Baltimore. Finally, when I moved from Washington to Baltimore, we two arranged a meeting of the Washington Branch with the medical women of Baltimore. This pre-organization meeting was held in the Medical and Chirurgical Faculty Building in May 1914. As speaker of the evening, Dr. Nordof-Jung of Washington presented a paper on "Twenty Years of Gynecology." A banquet followed; the women of the two cities became better acquainted; and the meeting was in every way a success.

The following November we called the Baltimore doctors together at Dr. Pollack's home, the society was organized, and Dr. Pollack was made the first president.

A constitution and by-laws were formally adopted, one of the rules providing that no person should succeed herself more than once in the presidency. To date the following doctors have served in this capacity: Dr. Flora Pollack, Dr. P. S. Bourdeau-Sisco, Dr. Caroline Benson Towles, Dr. Anna S. Abercrombie, Dr. Mary Cook Willis, Dr. Claribel Cone, Dr. S. Elizabeth VanDuyne, Dr. Maud M. Rees, Dr. Mary Louise Small, Dr. M. Virginia Beyer, Dr. Rachel Gundry, Dr. Katharine A. Chapman, Dr. Nelsa Lee Wade Evans, Dr. Grace G. Jones, Dr. Coral Gordon, Dr. Amelia Link-Sheppard, Dr. Mary S. Bulkley, Dr. Roselva Thompson-Daugharthy, and Dr. Eleanor Scott.

The objective of the society is the closer association of women physicians, the reading of medical papers, the presentation of cases, discussions, and general interchange of ideas.

For some time the meetings were held in the homes of the members, and were followed by a social hour. In later years we have had dinner meetings in public places, held monthly, from October to May. We have never failed to have a joint meeting with the Woman's Medical Society of the District of Columbia as a part of our program each year, Baltimore and Washington being alternate meeting places.

The broad outlook of the women was shown by the fact that Dr. Towles, with the assistance of Dr. Edith Ereckson, began the registration of all medical women in the United States, a work which was later continued by the A.M.W.A.

Another member, Dr. Elizabeth Hurden, of English birth, returned to England and enlisted for service during World War I. After the war she returned for a short time, and at one of our meetings gave us a most interesting account of her work.

Dr. Flora Pollack volunteered for war service in 1918 and served during the influenza epidemic in Virginia.

Some of our members, Dr. Abercrombie, Dr. Hoopes, and Dr. Towles, conceived the idea of starting a school for the rehabilitation of the blind soldiers of World War I. This ultimately developed into the wonderful school for blind service men at Evergreen.

We enjoyed the opportunity of honoring Dr. Amanda Taylor Norris, one of the oldest women in medicine in our midst, with a dinner at which she was placed between Dr. William Welch and Dr. Howard Kelly, both of whom spoke feelingly about her.

Another pleasant occasion was the dinner given at the College Club to honor Dr. Jennie N. Browne, Dr. Mary N. Browne, and Dr. P. S. Bourdeau-Sisco, all of whom had been in practice for twenty-five years.

Our society has grown since 1914, and we are proud to be Branch Three of the American Medical Women's Association.

ELEANOR SCOTT, M.D.

Guest Editor

This, the November JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, is the special number of Branch Three, Baltimore. The articles were collected under the supervision of DR. ELEANOR SCOTT, and we are grateful to her for obtaining such interesting and varied material.

Dr. Scott graduated from Cornell University Medical College in 1935, and later served a 2-year internship at the Philadelphia General Hospital. She was awarded the Mary Putnam Jacobi Fellowship in 1940, and devoted her year's research to analyzing lesions of the cervix discovered in periodic pelvic examinations of women.

From 1941 to 1944 Dr. Scott was associated with the Woman's Hospital of the State of New York, first as assistant resident and then as resident in obstetrics and gynecology.

Her present hospital appointments include obstetrician at Johns Hopkins Hospital, associate attending obstetrician and gynecologist at Franklin Square Hospital, and assistant attending obstetrician at Sinai Hospital of the South Baltimore General Hospital. . . . Ed.

International Congress of Dermatology

THE TENTH INTERNATIONAL CONGRESS OF DERMATOLOGY was held in London from July 21, 1952, to July 26, 1952, under the presidency of Sir Archibald Gray. About 1,200 members attended from all over the world. Headquarters were in Bedford College, Regent's Park. Scientific sessions were held in four or five halls at the same time making it impossible to attend all of them.

There were four main topics of discussion. *The Pathogenesis of Eczema* was discussed by Dr. J. C. Bellisario, Australia; Prof. O. Gans, Germany; Prof. J. Gate, France; Dr. D. M. Pillsbury, United States; Prof. G. Miescher, Switzerland; and Dr. R. T. Brain, Great Britain. All agreed on a word of warning that penicillin and the sulphonamides increase the general sensitivity of the skin. As eczema is primarily a hypersensitivity of the skin, the widespread use of these antibiotics is considered a potent factor in causing an increase in allergic skin diseases.

ACTH *and Cortisone Therapy in Dermatology* was outlined by Dr. Louis A. Brunsting, United States; Dr. L. P. Ereaux, Canada; Dr. Marion B. Sulzberger, United States; and Dr. F. T. G. Prunty, Great Britain. The consensus of opinion here was that cortisone had a definite influence on dermatology, more especially in very severe and usually fatal cases such as disseminated lupus erythematosus, pemphigus vulgaris, generalized scleroderma, and severe cases of psoriasis. Many minor skin diseases, such as erythema multiforme bullosa, are self limiting in duration and in the long run tend to clear up. It was suggested, therefore, that grave diseases might have a tendency to clear in the same way, but that one could not be sure, as the patient nearly always dies before that stage. Here ACTH could be of the utmost importance as it would tide the patient over the critical period and make recovery possible. It should only be given by experts as cortisone lowers the patient's resistance to pyogenic organisms and dangerous abscesses may occur at the site of injection. A history of any gastric trouble is a contraindication to this therapy as patients with fatal perforations have been reported. Initial doses of cortisone are from 100 to 400 mg. daily and when improvement has been established the dosage is reduced for adequate maintenance. There is no definite scale of dosage as each case has to be treated individually. It is important to note that as there is sodium retention while taking ACTH the patient should be kept on a low sodium diet and given sufficient fluids. On the whole the dose of ACTH injections is one-quarter that of cortisone.

The discussion of the *Treatment of Tuberculosis of the Skin and Allied Conditions* was opened by Dr. G. B. Dowling, Great Britain; Prof. J. Charpy, France; Dr. P. V. Marcussen, Denmark; Dr. E. A. Sainz de Aja, Spain; Dr. G. Riehl, Austria; Prof. M. L. O. Craps, in collaboration with Prof. S. Lapiere and Dr. H. Van Runcklen, Belgium; and Dr. G. Wetherley-Mein, Great Britain. In general it was agreed that calciferol vitamin D therapy was a marked advance on the Finsen light treatment. A judicious combination of the two is sometimes most efficacious. Cases which appear clinically cured can relapse after six to twelve months and, therefore, should be kept under observation for some years. These three main discussions will be published in full in a volume of Congress Proceedings.

The Successful Treatment of Leprosy during the past ten years has now made this disease no longer to be dreaded. The new sulphones have given excellent results and it was the opinion of all speakers that sulphetrone was the least toxic. Aqueous sulphetrone is given intramuscularly twice weekly for about three months using 600 to 800 mg. as the total dosage.

Reported by SPENSER SCOVELL, M.D.
London, England

World Health Organization

MENTAL HEALTH AND INFANT DEVELOPMENT

THE EMOTIONAL LIFE of a young child, particularly the nature of its relationship with its mother and father, may set the pattern of subsequent relationships in adult life, including the marriage relationship.

This was one of the dominant ideas emerging from the seminar on mental health and infant development sponsored by the World Federation of Mental Health, which recently finished a 3-week session at the Bishop Otter College in Chichester, England.

Participants from 28 countries, themselves specialists in psychology, psychiatry, maternal and child health, nursing, sociology, public health, and other branches concerned with the mental and physical well-being of children, were brought together at the seminar by the World Federation of Mental Health; World Health Organization; United Nations Educational, Scientific and Cultural Organization; the United States National Advisory Mental Health Council; the Grant Foundation of New York; and the International Children's Center of Paris.

Among the faculty members leading the discussions were Dr. John Bowlby, psychiatrist of the Tavistock Clinic, London, who showed a film illustrating the importance of child and parent relationships; Dr. Margaret Mead, anthropologist of the American Museum of Natural History, New York, who contributed material showing the nature of child-parent relationships under different culture patterns; and Prof. D. R. MacCalman, professor of psychiatry at Leeds University, who discussed the results of intensive case studies of children from industrial areas in northern England. He found a dominant factor in the treatment of children by parents was the concept that "life is hard" and the conviction that children must be brought up "tough."

Miss Anna Freud of the Child Study Center in London, reported on her prolonged investigation into the effects of war on children, especially the early forced separation from either or both parents. Miss Freud said that war had provided an enormous, involuntary experiment in child psychology, principally in early forced separation, which even in young children had a profound psychologic effect often manifested in physical form. Infants bereft of their mothers would develop colds, sore throats, intestinal disturbances, and other manifestations to an unusual extent, which, Miss Freud contended, were psychologic in origin. Somewhat older children would undergo retrogression in development. Some already able to walk and speak would cease doing so. Among a group of orphans from Auschwitz who lost both parents in very early infancy, Miss Freud observed, the affection normally bestowed to parents was transferred to other children of the same group. Jealousy between children, Miss Freud found, develops via parents and is essentially a competition for parental love.

However, adjustments made by children separated from parents, including sometimes the invention of "ideal" parents, never wholly replaced the natural relationship, although an enormous time lag was possible in the ultimate impact in the event of separation. Sometimes this was as much as five or ten years after which upheavals might occur, which, Miss Freud said, are often "enormously revealing." Miss Freud emphasized the cruelty, shortsightedness, and hardship of separating brothers and sisters of different ages entering orphanages. She exhorted orphanage administrators to reflect on this matter.

Dr. Jenny Roudinesco, psychiatrist from the Paris Hospital, told the seminar that she was so impressed by the apathy and lack of spirit among 2-year-olds in a large French orphanage, that she made the film "The Case of Monique," which unmistakably shows the serious degree of damage inflicted.

The child histories selected in the United States, France, and the United Kingdom were studied by the participants who generally felt that instead of the mechanistic approach towards child rearing, including the preference for bottle feeding so popular in certain countries a generation or so back, the aim should be to "work with nature, not to try to bend it," in the words of Dr. Margaret Mead. It was especially emphasized that the child-mother relationship should be disturbed as little as possible. As example, the profound psychologic shock experienced by small children sent to hospitals was illustrated in a number of documentary films.

The WHO sent 39 participants to the seminar from Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Ireland, Yugoslavia, the Netherlands, Norway, Spain, Sweden, and to Switzerland.

Woman As a Social Force

Ellen C. Potter, M.D.

THERE IS NO DOUBT that every one of us has, during the past few years, contemplated the world situation, and looked back along the road which has brought us to the brink of a third world war—hot or cold—and we have lifted our eyebrows or shrugged our shoulders and have said with some complaisance, "Well, they can't blame US for we have never been included in the inner councils of those who made the fateful decisions which have resulted in chaos."

I am not sure that we are justified in this assumption. At this mid-point in the twentieth century—and more than one full century since, in 1848, "Women's Rights" and "Votes for Women" became the slogans in this country—I say that women have suffered, and some still do, from an 'inferiority complex' which is not justified by the facts. This is not a man-made world; woman in these United States is not downtrodden, and the doors of opportunity stand wide in a multitude of directions provided woman is willing to travel the rugged road which leads to recognition in Government, in business, in the professions, and even in the career of wife, mother, and homemaker. It is important that we look into the past relationship between men and women, and I know of no more readily available text through which to take that long look than through Mary R. Beard's "Woman as Force in History," which is a study of the traditional subjugation of women, and the realities which existed in the historic past.

The female of the species carried the human race forward. In primitive society she alone was thought to be involved in the bearing of the child; she it was who, because of her children, stabilized the home, lighted the fire on the hearth, cooked the food, and so brought her man back to the fireside from his nomadic wanderings and his fighting with his fellow man. There have been great rulers among women, as Elizabeth of England, who took the first steps to provide through government for the welfare of the poor; and women have been great despots, as Catherine the Great of Russia, who was perhaps the worst of them all. You may remember reading of the French salons, conducted sometimes by women of great wealth and education, and have thought of them as an ancient form of the cocktail party of today. As a matter of fact, they were the only means available for the dissemination of new ideas, of criticism of the government or of religion, for the death penalty was prescribed for persons who "wrote or printed or distributed" any work critical in its nature of religion or of government or of government officials. It was through these "social activities" of women over a long period of time, that woman "became the greatest single influence in developing a civilized social behavior, promoted lucidity of written expression, and incited talents to flower in arts and letters."

Where does woman stand today in these United States as a social force expressed in political terms? She has had the vote for thirty years, and the right to vote was won for her in approximately fifty years, while man's struggle for that right covered generations. Has the winning of the ballot brought to women a real partnership with their brothers in the shaping of public policy in the interest of the welfare of our country? The facts are, and it is our own fault, that we have not prepared ourselves for public service in the political field. The statisticians tell us that only 1 percent of all elective or appointive posts in our Government are held by women, although women represent 52 percent of the electorate; they own 75 percent of the corporate wealth of the country, and by their education and training are on an equal competitive footing with men. Even so, we lack political representation. We are all proud of Margaret Chase Smith, now in the Senate and by her own well-earned right, not as the widow of a Senator; and the records of a goodly number of women, in and out of office, count to our credit. In the appointive field, Federal, State, and local, at the higher levels of administrative responsibility, our score is meager. Frances Perkins has been the only woman of Cabinet rank; Julia Lathrop, Grace Abbott, Katharine Lenroot, and Martha Eliot have carried the torch of child welfare during the past thirty years. Of the 48 state directors of public welfare departments, only 4 are women.

Look back but 110 years and what do we see? The first seeds planted for the higher education of women came into bloom at Mt. Holyoke Seminary; followed in less than ten years by the demand of a small group of women for medical education, first by the Blackwell sisters of New York. In 1849 came the creation of the Woman's Medical Col-

lege of Pennsylvania. It is generally agreed that those early medical women fought the bitter battle successfully against the odium which clung to the very idea that women should claim an educational status equivalent to that attained by men. Today all medical schools but one accept women as students, and in a large proportion of these colleges women are on the faculty.

One hundred years ago Dorothea Lynde Dix, a day school and Sunday school teacher, was called upon to teach a class in a local jail. She saw with her own eyes wrecks of humanity, mentally ill and incarcerated presumably for the safety of the public, rather than for treatment. She started on her crusade in behalf of the mentally ill, and her mission has influenced the whole civilized world in its program. It was the indomitable Clara Barton, who fought the battle in and out of legislative halls, who established the American Red Cross on a sure foundation and with governmental backing in the United States. Harriet Beecher Stowe, author of "Uncle Tom's Cabin" (published on March 20, 1852), stirred to its foundations not only our nation but also the world to realization of the crime of slavery; resulting in its abolition in the United States.

Let us bring our thinking more nearly up to date, concentrating on the ladies of Hull House in the early 1900's and thereafter. Jane Addams, the dynamic leader, "built a bridge between the classes" in an underprivileged area of Chicago, and embodied the best social spirit of our time. Florence Kelly, a power for human progress, was a leader of the Consumers' League now functioning all over the United States. Sophronisba Breckenridge, a lawyer, and one of a long line of distinguished Kentuckians, laid the foundations for public welfare administration and, together with others, established the first professional training school for social work, in 1899. But these are not all of the ladies of Hull House who have contributed to the welfare of the United States and to the world. Dr. Alice Hamilton in 1910 undertook to explore the dangerous trades, the industrial poisons, and the occupational diseases which had "poisoned American industry." Her research led the world in the correction of these industrial hazards. Even the great Medical School at Harvard University had to call her, the first woman member of its faculty, to a position as the authority on industrial medicine. Two other ladies of Hull House, Julia Lathrop and her successor, Grace Abbott, were called to Government service. Appointed by the President, Miss Lathrop created the Federal Children's Bureau; and Grace Abbott, appointed on Miss Lathrop's retirement, continued its development as one of the most dynamic units of the service on behalf of children, and a model for the world.

Last but not least are two other torchbearers who should be mentioned, for their work has had world-wide influence. One, who for the last years of her life was a citizen of New Jersey, Dr. Josephine Baker, created in the city of New York the first Public Health Service: first to reduce the appalling maternal and infant mortality in that city, and then to devise a program that should develop healthy, happy children. Her methods have had world-wide acceptance. The other torchbearer was Mary Richmond of Philadelphia, the head of the Family Society; later in New York on the staff of the Russell Sage Foundation, where she laid the groundwork for case work as we know it today.

These samples of accomplishment on the part of "Women as a Social Force" in the last fifty years are outstanding! Are we producing their like today? If not, why not? One thing that I can say of them all is this: not one of them sought personal aggrandizement; every one of them recognized the cause she served as being more important than she; every one of them had a warmth of personality which made friends for the cause she served and stimulated the lives of the younger generation whom she touched.

Now may I ask you to do some thinking. A very large proportion of the women I have cited were not married; especially should that be noted of those who have made their mark since 1900. Is that a count against them, or have they in their calling found a compensation for their womanhood? Every single one of them in her profession has served at her maximum the needs of human beings in fields of health, welfare, and education. Agnes Meyer in the August 1950 number of the *The Atlantic* says, "Women have many careers but one vocation, motherhood." And she continues, "As a result the most successful careers are motherhood substitutes, such as teaching, nursing, social work, medicine, psychiatry, and other scientific professions that protect the child and the family." She later adds what is pertinent to times like these with the uncertainties of war: "It is for woman as mother, actual or vicarious, to restore security in our insecure world—not the economic security on which we now lean far too much, but the emotional security for which the world longs as much as it longs for its daily bread."

Every one of us must find the answer, equipping ourselves for the duties which lie ahead and which we must assume for ourselves and for those who depend on us.

WITH THE AMWA AROUND THE WORLD

The American Women's Hospitals in Greece

AWH nurses, doctors, Miss Willms, and a few of the nurses of the hospital.

WITH AMERICAN HELP the first wing of a hospital planned twenty years ago by the Greek Government has been completed in the Nikaia-Piraeus district. And on June 25, 1952, a special ceremony dedicating a ward to the American Women's Hospitals was held in fulfillment of a promise made years ago.

On this occasion a plaque memorializing this service in Greece was unveiled. The ceremony was opened by the Bishop with a special prayer for the AWH committee of the American Medical Women's Association which maintains this service, and the other workers in the field, including the nurses trained in their school. A chorus of 50 nurses participated in the ceremony and an address was delivered by the president of the executive committee of the State Hospital outlining the history of the work of the American Women's Hospitals in Greece.

The guests present included Mme. Tsaldaris, wife of Premier Tsaldaris, who has been interested in the AWH work, particularly the training of nurses, over a long period of time; M. Marinos, chief officer of the Ministry of Hygiene; and other officers of the Department of Health and Public Assistance. When completed this hospital will provide between 500 and 600 beds and will serve a population of 400,000.

ESTHER P. LOVEJOY, M.D.

THE JOURNAL AND THE BRANCHES

With this, the November number, the JOURNAL publishes the third in its series of Branch Numbers—the articles supplied by Branch Three of Baltimore with Dr. Eleanor Scott as Guest Editor. These Branch numbers serve several purposes. They stimulate esprit de corps by arousing a little friendly competition among the geographic divisions of our Association. They preserve for our archives a printed report of the history of the Branches and of the pioneer women who were instrumental in founding these organizations. They acquaint us with the work of our contemporaries in these areas.

Thus we feel they contribute to the progress of our Association, and their continued publication should be encouraged. The fourth in the series, the project of Branch Four, New Jersey, is scheduled for publication in March 1953, Dr. Eugenia Geib as Editor. Other Branches are urged to take over an issue—we do not expect necessarily to maintain a numerical sequence—and are requested to write the Editor in order to reserve the month they wish for their publication.

As there are 31 Branches in the Association, it will take a number of years—almost a decade—at our present rate of two a year, to publish an issue from each of our Branches; therefore, the Editors must revise their programs to include more of these special numbers, and they will do so "on demand."

Even so it will take some time. Meanwhile the Branches need not be silent as the JOURNAL has a special department, NEWS FROM THE BRANCHES, which the Editors would like to expand into a vital, interesting month-to-month reporting of activities of all the Branches: news of their meetings, excerpts from papers read and discussed, awards or special recognition given members, social affairs in connection with meetings, projects under way, and similar news. We suggest that each Branch appoint a reporter to the JOURNAL who shall be responsible for sending these notes to the Assistant Editor, Dr. Marcelle Bernard, at JOURNAL headquarters, 2 Lexington Avenue; and that the reporter's term of office expire only when she fails to deliver the news! Several Branches are very active, have excellent and varied programs at their meetings, and are doing a fine job of public relations in their communities. Perhaps a report of their meetings may assist program chairmen of other Branches, and an account of their activities may stimulate more vigorous participation in Branch projects by the members. We KNOW these accounts will be interesting, so, *LET US HAVE THEM.*

A.C.R.

OPPORTUNITIES FOR WOMEN IN MEDICINE

Committee on Opportunities

Please send us promptly any announcements of openings for medical women either in residencies, positions, or practice.

If there are any fields our readers are especially interested in please advise us. We plan articles on industrial medicine and missionary work in future issues.

Address communications to: Dr. Margaret S. Tenbrinck, Chairman, Committee on Opportunities for Women in Medicine, American Medical Women's Association, 52 Gramercy Park North, New York 10, N.Y.

GRANTS-IN-AID

New research applications in the cardiovascular and related fields are now being accepted by the American Heart Association for studies to be conducted during the year beginning July 1953. Applications for research grants-in-aid may be filed up to December 1, 1952. Information and forms may be obtained from the Medical Director, American Heart Association, 1775 Broadway, New York 19. Applications will be reviewed by the research committee of the Scientific Council.

Grants-in-aid are available to non-profit institutions for a specified program of research including work in the basic sciences, under the direction of an experienced investigator; they are awarded in varying amounts, usually not exceeding $10,000, and the period covered is variable, depending on the particular program of study.

FULBRIGHT AWARDS

Of interest to many scholars is the fact that a Fulbright Agreement has recently been signed with Germany. It is possible that awards will be offered for the academic year 1953-54, although full details are not yet available. Applications for awards in Europe and the Near East close October 15; those for Asia on April 15.

American Medical Women's Association

PRESIDENT'S MESSAGE

THE MID-YEAR MEETING of the American Medical Women's Association is now at hand! The week after Thanksgiving will find many of us gathered together at The Broadmoor in Colorado Springs, Colorado, (Nov. 29 to Dec. 1, 1952) not only to hear reports from the officers, chairmen of Committees, and Branches of the AMWA, of work already accomplished and plans for the year, but also to hear an outstanding speaker, and to have a few days of pleasant fellowship in a fine hotel located in a country of unparalleled beauty.

In the October JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION I discussed procedure for sending of reports, and presented a preliminary program. Reservations for The Broadmoor are to be made direct with the hotel. A tear-out sheet on page 10 makes it simple for you to send your check ($10.50) for two luncheons and the banquet to Dr. Elizabeth R. Fischer, Corresponding Secretary.

BANQUET

It is our good fortune to have Dr. Carroll L. Birch as our banquet speaker. Dr. Birch, professor of internal medicine, University of Illinois, College of Medicine, who needs no introduction to any of us, has just returned from a year of important work in India as principal of the Lady Harding Medical College at New Delhi. She will give an illustrated talk on her experiences in India, Kashmir, and Jammu. Dr. Birch is a fascinating, dynamic speaker, and it is a rare privilege to have this opportunity to hear about life in these countries.

LUNCHEON

At the luncheon on Sunday, when Dr. Camille Mermod will preside, the reports of the Regional Directors and Branches will be heard. Many of these reports give unique and interesting suggestions for regional and branch activities.

The program at the Monday luncheon will be a resumé of the recent Council meeting of the Medical Women's International Association at Vichy, France. Dr. Eugenia Geib and other delegates will give brief reports.

AWARD OF MERIT

Another interesting feature will be the presentation, for the first time, of the Award of Merit ($100) to a senior medical student for outstanding scholarship.

Every member is welcome but only members of the Board of Directors may vote at the Mid-Year Meeting. Those of you who have not had the experience of attending a Mid-Year Meeting will be pleasantly surprised to find it a real pleasure. It is not too late to make reservations if you act at once. We can promise interesting discussions about our Association activities, outstanding speakers, and good fellowship in a beautiful hotel in a section of our country which has no equal.

Evangeline E. Stenhouse

Opportunities for Women in Medicine

MISSION MEDICAL SERVICE

As one reviews the literature and publicity circulated by the Christian Mission Societies it soon becomes apparent that the need for medical missionaries is tremendous and the field unlimited.

Appeals for missionaries come from all over. In most areas government attitudes and regulations are favorable; in a few, such as Latin America and Turkey, the conditions of license are almost prohibitive; in others, like India, there are signs of relaxing the conditions of professional registration. Most missionaries are assigned to general hospitals for general surgical and medical work. Most are in towns or cities, although some are in isolated places. The bed capacity averages about seventy. The majority are fairly well equipped and usually have a school of nursing and some interns. There is steady improvement of facilities and quality of the work. Increasingly the staffs are becoming nationalized.

It is emphasized that candidates must consider certain essentials in their preparation. Spiritual purpose and grasp, with active participation in the work of the church, come first. Personal qualities are necessary to make one liked and effective in all endeavors. Good health means a great deal in overseas work.

Professional training includes graduation from an approved medical school, preferably a rotating internship with considerable surgical experience, and a formal course in tropical medicine. Specialty Board diplomas are becoming increasingly important for those assigned to medical school faculties, although they are not yet recognized officially by governments. There is in general little chance to specialize. National Board examinations are preferable to State Boards because of wider application here and more general recognition abroad.

Choice of field and assignment depends on the individual's preference and the mission board's opinion. Final decision rests with the local mission.

Duties of the missionary include several aspects of his life. Aside from his professional practice he is expected to join in the religious life of the mission and in some cases to help conduct it. Increasingly nationals are being trained to take over the work. At first local doctors were trained by apprenticeship and later small medical schools were established. Before China was closed and Korea devastated there were ten recognized Christian medical schools in India, China, and Korea as well as a score of medical assistant training institutions in Africa. Schools of nursing are much more numerous than medical schools. There are 80 in Burma and Ceylon, and 2 of these are of college level. Besides providing staff members for the hospitals they have improved the status of women in countries where women were previously barred from a professional education.

Missions now need public health experts especially for outlining preventive medicine and public health programs, with the co-operation of local experts.

Openings in Missionary Service are outlined annually in "Christian Horizons," which is prepared by the Student Volunteer Movement for Christian Missions. In 1952 they list 52 mission locales, of which 24 are in South and Southeast Asia and 16 in Africa. The others are located in the Far and Near East, Alaska, the West Indies, and one in Bolivia. In many cases more than one doctor is needed. Most missions state whether they want a man or woman physician or a couple. Of the 12 specifying only a woman wanted, 11 are in India, Pakistan, Arabia, and Japan, and 5 others will take a woman, man, or couple. A couple only is specified by 23 missions, 11 of which are in Africa. No mission specifies only a man and only three want a man or couple, one being in Alaska and two in Puerto Rico. Seven specify no sex preference. This, therefore, is a field not only open to women, but one in which they receive preference.

Life "out there" may mean any one of a number of climates and communities. These vary from an African village or a Puerto Rican farming center to a Navajo community in Arizona. One doctor wrote from a village in Iran: "Of the 80 patients I saw only 3 had trachoma; in 20 I made a 30-second clinical diagnosis of malaria, and in 5 I strongly suspected tuberculosis. The others were all sick of a great variety of things. We held the clinic in the

house of the village owner and charged four eggs admission."

Another doctor wrote in 1951 from Korea after the war began: "We went out to a village in the plain to study the dread liver fluke. We set up our microscope on an old Singer sewing machine, the only available table, in the yard of a mud hut. Then we went fishing and were able to demonstrate to our interns and villagers the deadly cysts under the gills of the little fish, and in the clams they eat raw."

From Puerto Rico: "The people are poor, earning about $8 a week. They live in small huts that are very primitive. They are generally uneducated and undernourished, and full of intestinal parasites."

Recommended reading includes books written by medical missionaries, such as "Doctors Courageous" by Edward H. Hume, and "My Patients Were Zulus" by James B. McCord and John Scott Douglass.

There are still untouched areas in Tibet, Nepal, Afghanistan, and parts of South America where pioneers are badly needed and these locations should be a challenge to any woman desiring work in this inspiring field.

More detailed information is available from the individual denominational mission boards, Student Volunteer Movement, or the Christian Medical Council for Overseas Work, 156 Fifth Avenue, New York 10, N.Y.

MARGARET S. TENBRINCK, M.D.

REPORT FROM INDIA

We are always interested in reports from the field and quote from recent letters from Dr. Carol Jameson, who is at present at the Christian Medical College, Vellore, South India:

"In the past eight years the Christian Medical College staff has grown from no members qualified to meet university requirements to 90 doctors, and is now coeducational. There are eight departments headed by women: (1) obstetrics and gynecology, (2) x-ray, (3) ENT, (4) physiology, (5) anatomy, (6) pediatrics, (7) anesthesia, and (8) venereal disease. There will soon be one more, i.e., bacteriology, which will, by a concession of the university, be headed by a Ph.D. from Chicago. Others are all physicians. The departments headed by men are: (1) general surgery, (2) medicine, (3) neurosurgery, (4) chest surgery, (5) ophthalmology, (6) biochemistry, (7) pathology, (8) jurisprudence, (9) leprosy and dermatology, and (10) public health. There is also a research department in rehabilitation of leprosy cases. There are also surgical and occupational therapy. Urology, orthopedics, and plastic surgery are all under general surgery and handled by three senior men. Pharmacology is run by a non-medical woman. We have a school of pharmacology.

"Unlike other mission hospitals we can only use those with special qualifications after graduation. India now recognizes the Specialty Board examinations, which did not used to be the case as far as American degrees go. There is a new emphasis on pediatrics out here. Furloughs come at 5-year intervals and we then need replacements. The salary for a single person is $65 a month, which is plenty to live on here. About half our staff is foreign and for the most part sent out by 40 co-operative mission boards. All are expected to share in the religious work except for a few Hindus.

"Ludhiana Medical College in northwest India, and Muraj, near Bombay, are also recognized schools and the Ludhiana especially needs various posts filled. Then there are non-specialized posts throughout India.

"For openings at Vellore, applicants should apply to Dr. H. M. Lazarus, Director of the Christian Medical College, Vellore, India." From Dr. Douglas N. Forman, Secretary of the Christian Medical Council for Overseas Work comes this message: "Urgently needed are: a general surgeon, an ophthalmologist, an otolaryngologist, and an anesthesiologist. For openings at Ludhiana one should communicate with Dr. Eileen R. B. Snow, Principal, Christian Medical College, Ludhiana, Punjab, India. The urgent needs here are for a physiologist and a pharmacologist."

PUBLIC HEALTH SERVICE

Research Grants and Fellowships

THE PUBLIC HEALTH SERVICE research grants program is administered by the National Institutes of Health. Its purpose is to provide financial assistance for research in the health sciences to non-Federal institutions and individual scientists. The major objectives are:

1. To expand research activities in universities and other institutions.
2. To stimulate the initiation of research in small colleges where previous research programs have been limited or nonexistent.
3. To encourage investigators to undertake research in neglected fields.
4. To provide training for scientific personnel.

National Advisory Councils

National Advisory Councils, established by law and composed of outstanding citizens skilled in the medical sciences, education, and public affairs, examine all applications and recommend appropriate action. The Surgeon General may award grants only when they are recommended by one of the seven councils: National Advisory Arthritis and Metabolic Diseases Council, National Advisory Cancer Council, National Advisory Dental Research Council, National Advisory Health Council, National Advisory Heart Council, National Advisory Mental Health Council, and the National Advisory Neurological Diseases and Blindness Council.

Study Sections

In order that these advisory councils may have the benefit of the best scientific advice on applications for research grants, outstanding authorities in each of the major fields of research have been appointed as members of special study sections. Appointments are made to provide for rotation of membership. The majority of these special consultants are nongovernmental scientists selected by the Surgeon General on a nation-wide basis.

These study sections have accepted the responsibility (1) for reviewing applications for research grants in their respective fields, and forwarding their recommendations for approval, modification, further study, or disapproval to the appropriate National Advisory Council; and (2) for surveying, as scientific leaders, the status of research in their fields in order to determine areas in which research activities should be expanded. Study sections meet prior to the regularly scheduled meetings of the National Advisory Councils.

The applicant describes the research which he plans to do and provides information as to his training, experience, accomplishments, his work situation, and the facilities available. These factors are considered in detail with care by the study sections, since there is never sufficient money to grant all worth-while requests, it is necessary to provide a mechanism whereby requests compete on the basis of merit. The study sections and councils prepare a merit roll and the Surgeon General makes grants as far down the list as funds permit.

In order to insure scientific freedom and thereby promote the highest quality of research in both fundamental and applied fields, the investigators are not required to follow their original proposal but rather are free to pursue the research in whatever manner they wish and to publish their findings without clearance with the Government.

The Scope of Grants

In earlier years when the major causes of death were infectious diseases and the civilized world was continuously afflicted with severe epidemics and a very high infant mortality rate, scientists gave their attention primarily to these matters. As a result of their efforts, effective means for treating and preventing many of these diseases were discovered. General sanitation and nutrition improved and people began to live longer.

During the past few years there has developed among health agencies, physicians, and scientists an increasing preoccupation with chronic diseases of middle and old age. These diseases have increased as causes of death and disability largely as a direct consequence of the increased average life span of man. In order to keep pace with this changing emphasis of research, Congress has created in the Public Health Service's National Institutes of Health a series of new institutes concerned primarily with research in diseases such as cancer, arthritis, arteriosclerosis, and blindness.

It has not been the intention of Congress or the Public Health Service to decrease research efforts in fields such as infectious diseases but rather to maintain them at full vigor while stimulating additional research in the newer fields. The National Microbiological Institute and the Division of Research Grants have, therefore, continued to provide

research support in the field of infectious disease and general medical research.

It was recognized that this expansion of research effort could not be accomplished without expanding the research potential of the country. Research grants have made it possible for well-trained investigators to obtain additional assistants and equipment so that they could work at maximum efficiency. This has resulted in the training of a number of new investigators.

Research Fellowships

In addition, the Public Health Service conducts a research fellowship program to provide financial assistance to the most able and promising students and scholars during their training period so that they can enter a career of research in medical and allied fields. These fellowships are awarded on a competitive basis upon the recommendation of Institute specialty boards and committees of scientists at the National Institutes of Health. Annual stipends range from $1,600. Scientists anywhere in the world are eligible to compete. American citizens may receive training under these fellowships at any recognized institution in the world. A small number of fellowships have been awarded to foreign students for training in the United States.

Six Years of Grants

It is gratifying to note some of the developments during the first six years of the expanded grant program.

The volume of research has increased substantially. This increase has not been restricted to large institutions with well-established research programs. To be sure, such institutions have made a great contribution to this increased effort, but in addition —and perhaps of greater consequence in the long view—sound, substantial research programs have developed in other institutions widely distributed geographically and where little or no research existed before.

The availability of Federal funds has not diminished the degree of non-Federal support. In the period from 1946 to 1951, while Federal support was increasing twentyfold, there was a simultaneous fivefold increase of funds from private sources. Federal recognition of local ability has often provided a stimulus for increased local support.

From Public Health Reports, Vol. 67, No. 6, June 1952.

GRANTS AND AWARDS

Grants to aid cancer control projects in hospitals, medical schools, universities, and other non-Federal institutions, are given by the Public Health Service on recommendation of the National Advisory Cancer Council. Twenty-one grants were made in July 1952, of which several were for research for more effective methods of early diagnosis. Others were for support of professional education for cancer control, improvements of therapy, epidemiology studies, and investigation of environmental factors.

* * *

With the awarding in June of 72 grants-in-aid the American Heart Association has brought to over 4 million dollars the amount spent by the association or its local affiliates during its four years of financial support of research into heart and blood vessel disease. Grants have gone to research fellows, established investigators, and to career investigators, a post first established by the association. Further information about the grants may be obtained from the American Heart Association, 1775 Broadway, New York 19.

FELLOWSHIPS FOR GRADUATE STUDY

Applications for study in East Asia and the Pacific under the Fulbright Act for the academic year beginning in the spring of 1954 should be submitted between March 1 and April 15, 1953. The participating countries are Australia, New Zealand, the Philippines, Burma, Thailand, Japan, India, and Pakistan. Approximately 100 awards are available, for university lecturing or advanced research.

Detailed information and application blanks may be secured from the Conference Board of Associated Research Councils, Committee on International Exchange of Persons, 2101 Constitution Avenue, N.W., Washington, D. C.

* * *

Fellowships for graduate study in Switzerland are being offered by the universities of Basel, Bern, Fribourg, Geneva, Lausanne, Neuchatel, and Zurich, and by the American-Swiss Foundation for Scientific Exchange. Preference is given to applicants under 35, who have not previously studied abroad. A knowledge of French or German is required. Applications must be filed by March 1, 1953. Information may be obtained from the Institute of International Education, 1 East 67th Street, New York 21.

NELLE S. NOBLE, M.D.

DR. NELLE S. NOBLE, widely known physician of Des Moines, has been named "Woman of the Year" by the women's department of the Chamber of Commerce of Des Moines for her outstanding service to the community. This is the first time the organization has conferred such an honor, and the award is to become an annual event.

Dr. Noble was given the award for her services as vice-chairman of the health committee of the women's division of the Chamber of Commerce. Six groups were organized among which are a program of visiting nursing homes to entertain sick and elderly persons; a project to give assistance to poor and underprivileged families in Des Moines; and a cancer control and mental health program.

Born at Casey, Iowa, in 1878, Dr. Noble attended Drake University and received the degrees of Bachelor of Philosophy, Master of Arts, and Bachelor of Laws. After practicing law for two years, she retired to study medicine at Drake University. Dr. Noble was the first woman to intern at Methodist Hospital in Des Moines. She practiced general medicine and obstetrics for 44 years, and retired in September 1949. She had treated four generations of families.

Dr. Noble is a member of Phi Beta Kappa, and is listed in Who's Who. For over thirty years she examined Drake University women for their courses in physical education. She is a former member of the board of Drake University. Also, she has been active in a number of civic, study, and professional groups. She is a past President of the American Medical Women's Association (1939-1940); past regent of the Abigail Adams chapter of the Daughters of the American Revolution; past matron of the Des Moines Order of the Eastern Star; past president of the League of Women Voters, and of the women's division of the Des Moines Chamber of Commerce. She is a member both of the Library and of the Woman's Medical College Committees of the American Medical Women's Association.

Dr. Noble is modest about stories friends tell of her kindness, consideration, and charity. She is a physician who always has helped without thought of fees. At the time of her retirement, she said of the medical profession: "It's a most delightful type of living because you get so well acquainted with people and they are so kind and appreciative."

Those who have known and worked with Dr. Noble have indeed been privileged. She can well serve as an inspiration to the young women physicians of today. She has given freely of herself to serve her patients, to take an active part in civic affairs, and to be a faithful member of her church. Her life's work has been varied, fruitful, charitable, and valuable. There can be little wonder that Des Moines chose Dr. Noble its Woman of the Year.

MARCELLE BERNARD, M.D.

ALBUM OF WOMEN IN MEDICINE

CLARIBEL CONE, M.D.

AMONG THE OUTSTANDING women of whom Baltimore may well be proud is Dr. Claribel Cone, a woman of radiant personality and unusual charm, and a devoted pathologist. Baltimore is also deeply grateful to her for her philanthropy.

Dr. Cone was the fifth child in a family of 13 children. Born in Tennessee at the close of the Civil War, she was brought with her family to Baltimore at the age of six. Her early education was in the public schools, and in 1883 she was graduated from the Western Female High School.

It was about this time that a group of physicians, most of whom were graduates of the University of Maryland, founded the Woman's Medical College of Baltimore. For some years this was the only college south of the Mason-Dixon Line where women could receive medical training. Johns Hopkins University School of Medicine did not matriculate its first class until 1895.

Several years after completing high school, Dr. Cone was attracted to this new college for women, and decided on a medical career. In 1890 she obtained her diploma. The practice of medicine, however, did not appeal to her; her interest was in the laboratory. Through the gateway of pathology, she entered the Johns Hopkins Hospital to work in the laboratory of Dr. William H. Welch, professor of pathology.

Her unremitting diligence and enthusiasm made her a welcome guest and won for her Dr. Welch's lifelong friendship. In 1899, while at the hospital, she published, "On a polymorphous cerebral tumor containing tubercles and tubercle bacilli" (N.York M.J. 69:331; 361; 403), and in 1900, "Multiple hyperplastic gastric nodules associated with nodular gastric tuberculosis" (Johns Hopkins Hosp. Rep. 9: 877-890).

Her work with Dr. Welch lasted for ten years, from 1893-1903, during which time she was also professor of pathology at her alma mater. She was then ready for study in foreign laboratories. This was a time of great activity in bacteriology and research. Koch had isolated the tubercle bacillus in 1882 and was working with tuberculin in 1890. Pasteur, attracted by the work of Metchnikov, had given him laboratory facilities at the Normal School in Paris, and by 1892, his views on phagocytosis were established. Paul Ehrlich was working on his red dye and, in 1908, shared the Nobel Prize with Metchnikov. A few years before, Wasserman had established his reaction for the diagnosis of syphilis, and, in 1910, Ehrlich prepared the arsenical compound 606 for its cure.

This significant period in the advancement of the science of medicine found Dr. Cone sojourning in Europe, where she had the good fortune to become associated with some of these famous men, among them Metchnikov in the Pasteur Institute in Paris, and Ehrlich at the Senckenberg Laboratory at Frankfort-am-Main. A paper of hers was published in the *Frankfurter Zeitschrift für Pathologie* on the occasion of the Senckenbergianun Festschrift of 1907.

Dr. Cone was in Munich during the entire period of World War I, and it was at the close of the war that she met in Paris her old friend, Gertrude Stein, who caused her to turn her interest to another side of her gifted personality, the subject of

art. Miss Stein introduced her to several struggling artists who later became famous. Dr. Cone and her sister, who frequently was her traveling companion, patronized the modern school of painting in Paris as exemplified by Matisse, Picasso, Van Gogh, and Cezanne. They brought back many of the works of these artists to their joint apartments. Their small rooms were now filled to the brim. They also collected fine laces, textiles, jewelry, small chests, furniture, and rugs, many of which were brought back from their travels in the Far East. Their apartments became miniature museums. It was indeed a great joy to wander through the many rooms. This we were privileged to do during Dr. Cone's lifetime while she was president of our Woman's Medical Society of Maryland, from 1925 to 1927. Following her death in 1929, for twenty years, her sister, Miss Etta Cone, entertained our society royally in her sister's memory at each March meeting. It was at these meetings that we become familiar with the treasures. This collection became famous in art circles all over the country and attracted many of the intelligentsia. The Baltimore Sun published an article before Dr. Cone's death, which was tribute to a many-sided charming woman. It read: "Dr. Cone's Saturday parties . . . came as near being a salon as anything this city has ever known. To them came clever people in every walk of life . . . and the discussions which ensued sparkled with wit and wisdom."

Through the joint will of Dr. Cone and her sister, Baltimore was most fortunate in obtaining this vast collection, which is housed at present in the Baltimore Museum of Art. They also bequeathed $400,000 for the building of a new wing to install the collection permanently.

In the words of Mrs. Adelyn D. Breeskin, director of the museum, "The gift of such riches to the Baltimore Museum of Art is of tremendous significance. The Cone collection is world famous. which makes it fair to say that its public display greatly enhances the importance of our city as a cultural center. Since the problems of modern art are of great concern to us, this collection, which so admirably and lucidly illustrates its gradual development, will stand as a brilliant teaching vehicle. By means of this most valuable bequest the Cone sisters made it possible to extend their love of art among a large portion of our population, to act as a leaven for all of it."

BERTHA TAPMAN SHAMER, M.D.

THESE WERE THE FIRST

DR. MAY FARINHOLT JONES studied medicine after the death of her husband, and graduated in 1897 from the Woman's Medical College of Baltimore. She was the first woman physician at the Mississippi State College for Women (formerly Industrial Institute and College), the first woman doctor to take the Mississippi State Board medical examination, and the first woman physician admitted to the Mississippi State Medical Society.

DR. ANNA DENGEL, S.C.M.M., of the Austrian Tyrol, graduated in 1919 from the University of Cork, Ireland, and was sent to India to take charge of St. Catherine's Hospital for Women and Children in Ranalpindi. She founded The Society of Catholic Medical Missionaries, and is said to have been the first of the Catholic sisterhood to practice medicine in conjunction with her religious duties.

DR. SUSAN LAFLESCHE PICOTTE, graduate of the Woman's Medical College of Pennsylvania in 1866, was the first Indian woman to study medicine in the United States. She was a native of Walthill, Nebraska, the daughter of Pierre LaFlesche, last of the great chiefs of the Omaha tribe. She was a member of the Nebraska State Medical Society.

DR. KYING YUO ME, graduate of the Woman's Medical College of the New York Infirmary in 1885, is the first native Chinese woman to have received a medical degree in this country. She was an expert in microphotography and was made an honorary member of the Washington Microscopic Society before she returned to China.

DR. HELEN MACMURCHY, Companion of the Order of the British Empire, was a graduate in medicine from the University of Toronto in 1900, and the first woman physician admitted to the staff of Toronto General Hospital in 1901. For many years she was Chief of the Division of Child Welfare, Department of Health, Canada, and taught obstetrics and gynecology in the Faculty of Medicine of the University of Toronto. In 1949 she received the Elizabeth Blackwell citation given by Hobart College.

DR. SARAH WINDSOR, obstetrician in the maternity department of Massachusetts Homeopathy Hospital, Boston, was the first woman to hold this position (1904) and also was the first woman physician elected president of the Boston Homeopathic Medical Society.

ELIZABETH BASS, M.D.

News of Women in Medicine

Colorado. The University of Colorado School of Medicine announces the appointment of two new instructors in psychiatry: Dr. Garfield Tourney, formerly affiliated with the University of Iowa at Iowa City; and DR. CHRISTINE R. PAPENDREOU, who has been affiliated with the University of Minnesota Hospitals and Veterans Administration Hospital in Minneapolis, and the Boston City Hospital. Both will serve on the staff of Colorado Psychopathic Hospital at the Medical Center in Denver.

Florida. An obstetric seminar under the auspices of the Maternal Welfare Committee of the Florida Medical Association and the bureaus of maternal and child health of South Carolina, Georgia, and Florida, was held at Daytona Beach. One speaker was DR. EDITH L. POTTER of Chicago. Her topic: "Pulmonary Disturbance in the Newborn."

Georgia. DR. LUCILLE MARSH, formerly medical director of the regional office of the Children's Bureau in Atlanta, was transferred to Washington as of September 1. She is now chief of the Program Planning Bureau of the Health Services Division of the Children's Bureau.

DR. HELEN W. BELLHOUSE of Atlanta recently received the degree, Master of Public Health, from the University of North Carolina School of Public Health. She has been promoted from pediatric consultant to director of the Maternal and Child Health Division, Georgia Department of Public Health.

Illinois. At the annual meeting of the Chicago Gynecological Society, DR. JANET E. TOWNE was elected editor of publications.

DR. HUBERTA M. LIVINGSTONE of Chicago has resigned as chief of anesthesiology at the University of Chicago Clinics. She has been on the surgical staff of the University of Chicago since 1928. Recently she was awarded an honorary key by the medical alumni of the university.

New York. September has been proclaimed "Jewish Sanitarium and Hospital For Chronic Diseases Month" by Mayor Vincent R. Impellitteri of the city of New York. DR. JANET BALDWIN discussed, "The Use of Cortisone in Rheumatic Infection" at a seminar in chronic pediatrics held in the Albert Temple Auditorium.

DR. ALICE MOORE

The function of the virus section of Sloan-Kettering Institute is the study of the possibilities of control of cancer growth by infection of the cancer tissue with viruses capable of destroying it. The section was organized in 1948 under the leadership of DR. ALICE MOORE. She was born in 1908 in Bellevue, Ohio, and attended Ohio State University, majoring in bacteriology. After a few years in the veterinary pathology department she received a fellowship in bacteriology and obtained a Master of Arts degree. Dr. Moore came to New York and worked at the Rockefeller Foundation under Dr. Thomas Francis, Jr., who was doing pioneer work with influenza, and thus she was initiated into the virus field. When he left to become professor of bacteriology at New York University, Alice Moore went to medical school and was graduated from New York University School of Medicine in 1942. After a medical internship at Bellevue, she returned to Rockefeller Foundation as head of the yellow fever vaccine laboratory. After World War II, Dr.

Moore practiced general medicine for a few years and then returned to do research in viruses at Sloan-Kettering Institute for Cancer Research.

Various forms of therapy designed to help solve emotional problems are described in a book, "Specialized Techniques in Psycho-therapy." Dr. Gustave Byshowski, assistant professor of psychiatry, New York University and Dr. J. Louise Despert, associate professor of psychiatry, Cornell University Medical College, are the editors of the book, which contains chapters by nineteen of the country's leading psychiatrists, psychoanalysts, and psychologists. The book is the result of a 7-year project of the Psychiatric Forum Group to make available an exchange of information and ideas on psychiatry and allied social sciences.

Capt. Shirley Gage of Delanson, New York, is an Army doctor assigned to a field hospital in South Korea. She was graduated from Albany Medical School in 1948 and volunteered for a Friends service unit in China, where she became the only doctor in a 50-square-mile area in Honan province. During the upheaval in 1948 and 1949, she cared for as many as 400 patients a day, most of them natives suffering from wounds and illnesses resulting from Communist raids. Being behind the Iron Curtain, the village with its hospital was considered in Communist territory. Supplies were cut off entirely. After eight months the supplies were nearly exhausted and Dr. Gage initiated a public health program in an effort to stamp out war borne disease at the source and thus to conserve her precious drugs. Finally in the spring of 1950 the Friends reluctantly withdrew the service hospital unit. Dr. Gage returned to Delanson where she practiced until she received her commision in October 1951. At the present time she is stationed with the Third and Fourteenth Combined Field Hospital in South Korea. This is a 10,000-bed United Nations prisoner-of-war hospital.

Dr. Caroline A. Chandler of New York is the author of "Famous Men of Medicine" (Dodd, Mead and Company). She received her medical degree, cum laude, from the Yale School of Medicine in 1933. She was research fellow in pediatrics at the Harvard Medical School; assistant dispensary pediatrician at Johns Hopkins Hospital, and is now assistant professor of preventive medicine and instructor of pediatrics at the Johns Hopkins School of Medicine. She is also the author of several juvenile books.

Barnard College's first staff psychiatrist is one of her own alumnae, Dr. A. Louise Brush. Dr. Brush has been connected with the college on a part time basis since 1946. She also practices privately and at the New York and Presbyterian Hospitals. Her offices are open to Barnard students for an average of seven to eight hours a week and she sees about sixty girls a year. The problems she treats range from difficulties with studies to conflicts with parents. Like the medical treatment, the psychiatric treatment provided by the college is of a preventive or stopgap nature. Students who see Dr. Bush are channeled through another alumna, Dr. Marjory Nelson, Barnard's staff physician. Dr. Nelson, who has two children of her own, is a bustling, efficient woman with a firm belief that something can be done for the emotional as well as the physical needs of students. "If a girl gets a chance to air her problems to someone with an objective point of view," she says, "she is less apt to have chronic indigestion or colds." Dr. Nelson also gives a lecture course on Modern Living. She lectures on the fundamental ABC's of personal hygiene, sex, reproduction, child development, and community health problems.

New Jersey. Dr. Mary Bacon of Bridgeton, is secretary of the Cumberland County Medical Society for the year 1952-1953.

Ohio. Dr. Lena A. Lewis of the research division of the Cleveland Clinic Foundation has reported new methods by which the various lipoprotein fractions (combinations of lipid or fatty substances and proteins) in the blood can be separated and differences in their concentrations determined under various conditions. The ultracentrifuge, and the process of electrophoresis, are used. Although no definite conclusions have been drawn, this method is regarded as a valuable device for probing the many unknown mechanisms behind arteriosclerosis and hypertension.

Pennsylvania. "A Century of Medicine 1848-1948,"a history of medicine in the Commonwealth of Pennsylvania, has just been published by the State Medical Society. Among the medical "firsts" in this country, which it lists for Pennsylvania, are the following: the first general hospital, first permanent medical periodical, the first board of health, and the fact that the first woman's medical school in the world was established in Philadelphia more than a century ago. The Medical Society of the State of Pennsylvania was the sixteenth state society to be organized, coming into being one year after the founding of the American Medical Association.

Two women from South India, Dr. Jayalakshmi Y. Ayer and Dr. Kithiandra Thangama Ganapathy, will be postgraduate students at Woman's Medical College of Pennsylvania in the de-

partments of gynecology and pediatrics, respectively. Dr. Ayer has been sent to America by her Government, the Mysore State, for a 3-year training period in obstetrics and gynecology. Dr. Ganapathy is in America under an international grant of the American Association of University Women.

The Woman's Medical College has received a gift of $25,000 from the American Federation of Soroptimist Clubs, which sum will be expended over a 5- to 10-year period for various projects. The grant will be made each year in honor of an outstanding student, who will receive a Soroptimist citation. The first grant of $2,000 has been allocated to the preventive medicine department, and the student selected to be honored is BARBARA ANNE BURKE of Minneapolis, Minnesota, a fourth year student.

DR. NEVA M. ABELSON was one of the instructors in a 3-day course, "Practical Pediatric Hematology." This course was given under the auspices of the Graduate School of Medicine, University of Pennsylvania, from September 9 to 11.

Tennessee. DR. HELEN JOHNSTON of Jackson, Tennessee, is a member of the committee on scientific work of the *Journal of the Tennessee State Medical Association.*

A shortage of trained anesthetists has prompted the University of Tennessee Medical College to offer a postgraduate course in anesthesia. DR. MARY FRANCES POE is head of the department of anesthesiology. She feels that the course will give properly qualified registered nurses a chance to enter the field of anesthesia.

DR. DAPHNE SPROUSE is chief resident surgeon at St. Thomas Hospital in Nashville, Tennessee. She is the first woman to have this title. Dr. Sprouse received her medical degree from Vanderbilt Medical School.

International

Iceland. Assisted by the exchange program of the Department of State, Dr. Hjalti Thorarinsson and his wife, DR. ALMA ANNA THORARINSSON, of Iceland, have been offered simultaneous scholarships at the University of Wisconsin General Hospital in Madison, Wisconsin. Dr. Alma is a graduate of the Iceland Medical School, Reykjavik. She will take her internship at the University of Wisconsin.

Turkey. DR. MUENEVVER YENERMEN, assistant professor of pathological anatomy at Istanbul University, is doing research on alloxan diabetes at the National Institutes of Health, Bethesda, Maryland. Her husband, Dr. Muammer Yenermen, State Hospital pathologist in Istanbul, is doing neuropathology at the Armed Forces Institute of Pathology.

DR. SUZAN TURAN of Biga, Turkey, is a resident in radiology at the Jersey City (New Jersey) Medical Center.

General

The twenty-first annual meeting of the American Academy of Pediatrics was held recently in Chicago, Illinois. DR. JANET W. MCARTHUR of Boston, Massachusetts, took part in a round-table discussion, "Adolescent Girl and Her Menstrual Problems." "Celiac Syndrome" was discussed by Dr. DOROTHY ANDERSON of New York City, and DR. EDITH L. POTTER of Chicago told about "Emergency Care of the Newborn." "Personality Development in Infancy and Childhood" was the topic presented by DR. MARGARET GIRARD. DR. HATTIE E. ALEXANDER of the city of New York took part in a symposium on Neurologic Conditions in Childhood and discussed, "Infections of the Central Nervous System." DR. MILA PIERCE and DR. KLARA PREC participated in clinic conferences on Erythroblastosis and Congenital Heart Disease.

The American Association of University Women announces the Ida S. Scudder International Grant of $500, a gift of the Scudder Association, to help a woman physician from India to study in the United States. Dr. Scudder, who in 1918 founded the Vellore Christian Medical School for women, celebrated her golden jubilee of medical work in India in 1950. The school, now affiliated with the University of Madras, has recently admitted men students.

In a preconvention rush of activity, Congress completed action on several bills of interest to physicians. Among these a law was enacted which will authorize the military services to commission women physicians in the regular medical departments.

DR. DOROTHEA POSUNG CYNN has been awarded the Mary Putnam Jacobi Fellowship for 1952. She has been accepted by the Graduate School of Medicine of the University of Pennsylvania for the basic course in obstetrics and gynecology. Dr. Cynn was born in Chung Chung Nam-Do, Korea, in 1922, and was graduated from the Seoul Women's Medical College in Seoul, Korea, in 1944. She always took third or fourth place in her classes in college and medical school. Dr. Cynn interned at the hospital of Seoul Women's Medical College. For several years she was medical officer in obstetrics in the obstetric and gynecologic department of the Seoul City hospitals. In 1949, Dr. Cynn came to the United States and has served in St. Barnabas Hospital in Newark, New Jersey; Margaret Hague Hospital in Jersey City, New Jersey; and Hackensack General Hospital.

NEW MEMBERS

California

Margaret R. Wright, M.D.—1805 West 12th Place, Los Angeles.

Colorado

Katharine H. Chapman, M.D.—527 N. Tejon Street, Colorado Springs. *Ill. 1, 1925.* Oph*

Illinois

Theresa Felicetti, M.D.—1400 Long Avenue, Chicago. *Ill. 42, 1921.* GP

Pennsylvania

Aileen Schearer Geiger, M.D.—419 Douglass Street, Reading. *Pa. 7, 1949.*

South Dakota

Helen Jane Hare, M.D.—603½ Main Street, Rapid City. *Ill. 1a, 1949.* D

Wisconsin

Elizabeth Allen Steffen, M.D.—610 College Avenue, Racine. *Que. 1, 1945.* ObG

Associate Members

Emily Margaret Gray, M.D.—Glockner Penrose Hospital, Colorado Springs, Colorado.

Ann H. Lammers, M.D.—St. Francis Hospital, Evanston, Ill.

Mary Phyllis Matteson, M.D.—Univ. of Kansas Med. Center, Kansas City, Kansas

Junior Members

Winnie Jo Sosebee—2917 Hawthorne Ave., Dallas, Texas

*See A.M.W.A. Yearbook, page 31, or A.M.A. Directory, for explanation of code used in this listing.

KEEP YOUR DIRECTORY UP TO DATE

The following are recent changes of address:—

California

Helen Mackler, M.D., 517 Haberfelde Building, Bakersfield

***Rhoda U. Musgrave, M.D.**, 731 So. Tamarind, Fontana

***Yoshiye Togasaki, M.D.**, 1154 Oak Hill Rd., Lafayette

Gertrude Turner Huberty, M.D., 826 Glenmont Ave,. Los Angeles

Helen M. Trotter, M.D., 2262 St. James Rd., Newport Beach

Ruth E. Ellis, M.D., Casual Personnel Section A.P.O. No. 613, San Francisco

Lt. Col. Clara Raven, M.D., Osaka Army Hospital, 8009 Army Unit, A.P.O. 1007, San Francisco

Mary Gilbert-Knowles, M.D., 16 Hillcrest Dr., San Rafael

District of Columbia

Jeanne C. Bateman, M.D., 1339 H St., N.W., Washington 5

Martha M. Eliot, M.D., 4802 Jamestown Rd., Washington

Lucille J. Marsh, M.D., Children's Bureau, Rm. 4006, Fed. Sec. Bldg., Washington

Barbara Moulton, M.D., 4550 Conn. Ave., N.W., Washington

Florida

Bertha W. Ellis, M.D., P.O. Box 2327, Hollywood

Roslyn Skyer, M.D., 3801 N. Poinsetta Ave., W. Palm Beach

Georgia

W. Elizabeth Gambrell, M.D., 151 Ponce de Leon Ave., Atlanta

***Erma Smith, M.D.**, V.A. Hospital, Dublin

Illinois

Fannie Skolnik, M.D., 2818 W. Jarvis, Chicago 45

Ruth F. Rominger, M.D., 418 28th Ave., Moline

Iowa

Emma M. Ackerman, M.D., 718 Badgeron Bldg., Sioux City 1

Louisiana

Louise A. Box-Hutchinson, M.D., 1632 Claiborne Towers Apts., New Orleans

New Jersey

Helen E. Daniells, M.D., 18 Brook View Terrace, Hillsdale

New Mexico

Grace F. Thomas, M.D., 1907 Anderson Ave., Albuquerque

Charlotte McCarthy, M.D., c/o de Glisze, 1401 Canyon Rd., Sante Fe

New York

Else Pappenheim-Frishauf, M.D., 225 W. 86 St., New York

Elise Strang L'Esperance, M.D., 535 Pelham Manor Rd., Pelham Manor 65

Ohio

Alice-Eugenia Black-Schaffer, M.D., Univ. of Cinn. Coll. of Med., Dept. of Path., Cincinnati 21

Patricia Verrall Adams, M.D., 302 Lansdowne St., Springfield

Oregon

Amelia H. Lipton, M.D., 245 S.W. Birdshill Rd., Portland 1

***Mildred Esther Scott, M.D.**, 2805 Raleigh, N.W., Portland 10

Pennsylvania

Theodora Peck Dakin, M.D., Box 15, R.D. 2 Murrysville

Loretta B. Vogel, M.D., 1542 Evergreen Ave., Pittsburgh 9

Virginia

Madge D. May, M.D., 530 Birmingham Avenue, Norfolk

Washington

***Lena F. Schreiber, M.D.**, Box 445, Vancouver

Wisconsin

***Hallie Hartgraves, M.D.**, Kemper Hall, Kenosha

Isabel V. Estrada, M.D., Mt. Sinai Hospital, Cor. N. 12th & W. Kilbourne, Milwaukee

Canada

Helena B. Hale, M.D., The Provincial Hospital, St. John, N.B.

BOOK NOTICES

(Editor's Note:—These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of the JOURNAL.)

SURGERY AND THE ENDOCRINE SYSTEM—Physiologic Response to Surgical Trauma—Operative Management of Endocrine Dysfunction. By James D. Hardy, M.D., F.A.C.S. Assistant Professor of Surgery, University of Tennessee Medical College, Pp. 153 with 43 figures. Price $5.00. W. B. Saunders Company, Philadelphia and London, 1952.

In this monograph, Dr. Hardy exhibits an exceptional skill for condensing diversified opinions on intricate subjects into a clear and concise resumè. In order to accomplish this end, there is some oversimplification. The end result however, is a very readable exposition of his material.

The book is concerned with two phases of the surgeon's interest in the endocrine glands. The first portion reviews the relationship of the hormones to pre- and postoperative care. In so doing, it presents a thorough summary of the modern concepts of fluid and electrolyte balance, nutrition, and "alarm reaction," infections, tissue repair, early ambulation, and so forth. The fundamental concepts are stressed but are always related to practical problems in such a way as to make the book a valuable guide to the practicing physician.

The second portion of this monograph deals with the diagnosis and treatment of diseases of the specific endocrine glands. Newer diagnostic methods are outlined and both surgical and medical treatment are well summarized.

Because of the neat manner in which a great deal of new information has been boiled down and presented, this book should be a valuable aid to the undergraduate student, and a refreshing review for the practicing physician looking for a clear exposition of new developments.

—Donald R. Cooper, M.D.

A TEXTBOOK OF ORTHOPEDICS, with a Section on Neurology in Orthopedics. By M. Beckett Howorth, M.D., Clinical Professor of Orthopedic Surgery, New York University Post-Graduate Medical School. In association with: Fritz J. Cramer, M.D., Donovan J. McCune, M.D., A. Wilbur Duryee, M.D., J. William Littler, M.D., Walter A. Thompson, M.D. Pp. 1110, with 463 figures. Price $16.00. W. B. Saunders Company, Philadelphia and London, 1952.

Dr. Howorth has covered the field of orthopedics and has included an extensive section on neurology as it applies to the subject. In general, the text attempts to be a complete one, and therefore crowds a tremendous amount of information into one volume. Considerable detail is spent not only in diagnosis and roentgenographic findings, which are amply illustrated by excellent photographic plates, but also on operative procedures and postoperative care which are fully outlined. Here and there serious omissions are made, unfortunately, e.g., the lack of adequate description of the role of adductor contracture in the postnatal development of dysplasia of the hip, and its simple treatment. The exposition on fractures assumes a good deal of prerequisite understanding and is fairly breezy in its treatment and prognosis.

The grouping of discussions is somewhat unusual. There is an attractive historical introduction followed by a useful though an abbreviated section on anatomy. All types of orthopedic treatment are then presented in a separate extensive chapter. The remainder of the book is divided between regional orthopedics and orthopedic disorders. The appendix on neurology follows.

The book is well written. Its greatest value lies in its extensive bibliography on each of the subjects covered. In summary, it may be said that this is an excellent survey volume for students because of its wide coverage, and its extraordinary detail makes it a good reference book.

—Peter Viek, M.D.

MEDICAL GROUP PRACTICE IN THE UNITED STATES: A Summary of Recent Published Material and Supplementary Unpublished Data on Fees and Volume of Work. By G. Halsey Hunt, M.D., and Marcus S. Goldstein, Ph.D. Public Health Service Publication No. 77. Pp. 70, 21 tables and 5 figures, with 24 appendix tables. Price $.25. United States Government Printing Office, Washington, 1951.

This is a summary of recent published and unpublished statistical data about group practice, including information on personnel and organization, volume of work, and fees. No critical discussion is given, but the information supplied would be most useful to anyone planning the formation of a medical group. References are included.

—M. Eugenia Geib, M.D.

A TEXTBOOK OF PHARMACOLOGY: Principles and Application of Pharmacology to the Practice of Medicine. By William T. Salter, M.D., Professor of Pharmacology, Yale University School of Medicine. Pp. 1240, with 284 figures. Price $15.00. W. B. Saunders Company, Philadelphia and London, 1952.

This text deals with the application of medical pharmacology to the practice of medicine, and as such can be used as a reference book by medical students.

The volume is divided into four parts, the first section being devoted to the history and general principles of pharmacology and the relation of the physician and the pharmacist to the care of the ill patient. The mode of administration of drugs and various drug actions are discussed. The second part details the action of drugs upon physiologic mechanisms, grouping them as antipyretic, analgesic, anesthetic, anticonvulsant, stimulant, germicidal, and so forth. The third section describes the action of drugs upon the various systems of the body. For example, the circulatory system is discussed in relation to drugs acting upon the heart and blood vessels: cardiac stimulants and depressants, diuretics, coagulants and anticoagulants, and regulators of acid base and water balance.

The toxicology of drugs occupies the last portion of the book.

—Clementine E. Frankowski, M.D.

YOU AND YOUR AGING PARENTS. By Edith M. Stern; with Mabel Ross, M.D., United States Public Health Service, Director, Prince Georges County Mental Health Clinic. Pp. 212. Price $2.75. A. A. Wyn, Inc., New York, 1952.

Here is a small volume which should give aid and comfort to the many thousands of families whose happiness is jeopardized by the problems of caring for aging parents, and promotes a happier solution for all concerned. Several solutions are suggested in chapters

titled, to mention only a few, "You Live Apart," "You Live Together," "The Share of Your Brothers and Sisters," and "Your New Family Pattern." The book assures the son or daughter that she need have no guilt complex if she does not immediately welcome her parents into her home, where such a move might be disastrous to all concerned because of overcrowding, uncongeniality, or other equally good reasons. Children are wisely advised to disregard public and neighborly opinions, and leave the parent whenever possible in his own familiar home. The authors suggest that it is often better to board an aging parent with contemporary friends or with strangers, since under such a plan all parties are apt to be on better behavior. Social activities and purposeful hobbies are advised, and an independent allowance, however small.

The reviewer would like to see this very timely book appear in serial form in one of the large national magazines. It should be read by aging parents and their children, and by physicians who are called upon to treat the organic and psychosomatic ailments of both groups.

—Alice K. Hall, M.D.

SURGICAL FORUM: Proceedings of the Forum Sessions, Thirty-Seventh Clinical Congress, American College of Surgeons. Surgical Forum Committee. Pp. 667, with 290 figures. Price $10.00. W. B. Saunders Company, Philadelphia and London, 1952.

This compilation is comprehensive since it includes 12 divisions, with over 100 articles contributed by some 300 collaborators. The emphasis, as Dr. Wangensteen points out in his foreword, is on the chemistry rather than the carpentry of surgery, and contains the latest work in research, based largely on animal experimentation. For any surgeon who wants to go beyond mere technical advances made in his profession, the book is invaluable.

There are several articles, quickly applicable to one's everyday work, such as an evaluation of the exposure treatment of burns, the use of a compression suture in prevention of postoperative hematoma, suture strength and healing, strength of end-to-end intestinal anastomosis, and an article on Geiger counter studies of intra-thoracic malignant diseases. The articles are given in full detail and have many excellent illustrations. They represent a tremendous amount of painstaking worthwhile research. There are included, also, a number of abstracts of articles on related subjects.

All in all, the volume is a collection of studies for the surgeon who wishes to understand or to undertake the further study of the underlying basic problems of our present day concepts and practice of surgery.

—M. E. Williams, M.D.

ELEMENTARY MEDICAL STATISTICS: The Principles of Quantitative Medicine. By Donald Mainland, M.B., Ch.B., D.Sc., F.R.S.E., F.R.S.C., Professor of Medical Statistics, Division of Medical Statistics, Department of Preventive Medicine, New York University College of Medicine. Pp. 327, with 23 figures. Price $5.00. W. B. Saunders Company, Philadelphia and London, 1952.

To the many persons who have always looked upon statistics as an exceedingly dull subject, this compact series of lectures offers an interesting surprise; and when one reads early in its pages that "anyone who takes a blood pressure reading and decides that it is normal is dealing with statistics," the relevance of the subject to the practice of medicine is evident.

The purpose of the book is to teach medical students, and those physicians not acquainted with statistics as related to clinical medicine, the sources of error in statistics; presenting a plain and practical standard to judge statistics as they are used in research both basic and clinical. This enables the physician to set up simple standards to judge the impressions he is bound to accumulate in the treatment of patients. In short, the book will help every doctor to pursue planned therapy. This discussion occupies seven chapters.

The eighth and final chapter contains help and mathematical formulae for investigators who wish to set up more complicated problems. Many will not need this help, but one cannot but be interested in the subject of medical statistics which is now being offered to undergraduate students in some medical schools.

—Margaret H. Austin, M.D.

BIOCHEMISTRY FOR MEDICAL STUDENTS. By William Veale Thorpe, M.A., (Cantab.), Ph.D. (Lond.), Reader in Chemical Physiology, University of Birmingham. Fifth Edition. Pp. 528, with 41 illustrations. Price $6.00. J. B. Lippincott Company, Philadelphia, 1952.

This text on biochemistry follows the general style and organization of the previous editions in presenting an orderly study of the chemical processes occurring in living tissue. Since it is written for medical students, the chemical details of laboratory synthesis are not detailed. However, chemical formulate are used freely to explain chemical changes.

The fact that five editions of this work have been published since 1938 suggests the advances and changes which have occured in biochemistry during the period. The author states that the establishment of the tricarboxylic acid cycle of Krebs, which points out the final metabolic pathway common to amino acids, carbohydrates and fats, is in itself an advance sufficient to justify a new edition. The student will find that the evidence for the interconversion of carbohydrate, fat, and protein is presented so clearly and logically in the chapters on metabolism, that he can readily understand the chemistry of the changes.

To an American, the chapters on nutrition are particularly informative. Recommended daily allowances as prescribed by the Committee on Nutrition, British Medical Society, are compared with those of the National Research Council of the United States. Statistics are quoted which prove that in spite of the restrictions and strains of the war period, the general health of the population, and of children in particular, has been maintained, if not improved.

Although this biochemistry is for medical students, it should be a helpful source of information for the practicing physician who realizes that his understanding of chemical processes, particularly metabolism, is inadequate.

—Eloise Parsons, M.D.

WOMEN—AND THEIR MONEY. By Maxwell S. Stewart. Public Affairs Pamphlet No. 146. Pp. 32. Price $.20. Public Affairs Committee, New York, 1952.

Pointing out that one out of every six families in the United States is headed by a woman, Mr. Stewart discusses briefly the major financial problems likely to confront the female head of a household. Budgeting is outlined briefly, and the major portion of the pamphlet devoted to a discussion of life insurance and investments. References are listed.

—M. Eugenia Geib, M.D.

Current Publications of Medical Women

Knaibl, Paula Victoria: Plastia de parpado superior [Plastic surgery of upper lid]. Arch. uruguayos de med., cir. y espec. **38:** 51-54, Jan.-Feb. 1951.

The technique and a case are described.

Rosenthal, M. C., Saunders, R. H., Schwartz, L. I., Zannos, Leda, and others: The use of adrenocorticotropic hormone and cortisone in the treatment of leukemia and leukosarcoma. **Blood, 6:** 804-823, Sept. 1951.

(From Ziskind Research Laboratories (Hematology Section), New England Center Hospital, and Department of Medicine, Tufts College Medical School, Boston.)

Forty-two patients with various diseases of leukocytic proliferation were treated with one or more courses of adrenocorticotropic hormone or cortisone. The results are described and the therapeutic effects are evaluated.

Thomas, Caroline Bedell: The cardiovascular response of normal young adults to exercise as determined by the double Master two-step test. Bull. Johns Hopkins Hosp. **89:** 181-217, Sept. 1951.

(From Department of Preventive Medicine, The Johns Hopkins University School of Medicine, Baltimore.)

Using the double Master two-step test the patterns of cardiovascular response to standardized exercise of 263 healthy young adults were studied. The findings are described.

Seligman, A. M., and **Ashbel, Rivka:** Histochemical demonstration of ketosteroids in virilizing tumors of the adrenal cortex. Endocrinology **49:** 110-126, July 1951.

(From Yamins Laboratory for Surgical Research, Beth Israel Hospital, Boston, and Department of Surgery, Harvard Medical School.)

Ketosteroids were demonstrated histochemically in tumor cells of five virilizing tumors of the adrenal cortex in man and in an experimentally induced adrenal cortical carcinoma. The case histories are briefly presented and the histochemical results illustrated and discussed.

Wallace, Helen M., Abramson, H., and others: Formula rooms for newborn infants in lying-in hospitals; results of a municipal educational program to modernize preparation of formulas; with special reference to terminal sterilization. J. Pediat. **39:** 337-345, Sept. 1951.

(From New York City Department of Health and Department of Pediatrics, New York Medical College, Flower and Fifth Avenue Hospitals.)

Tenative impressions on the results of a continuous program from 1947 to 1949 by the Department of Health, New York City, are presented.

Benedek, Theresa: The sexual cycle and personality. J. Am. M. Womens A. **6:** 335-340, Sept. 1951.

(From Institute for Psychoanalysis, Chicago.)

General discussion of findings based on study of recorded psychoanalytic material.

Enlows, Ella M. A.: Recent advances in the field of otolaryngology. J. Am. M. Women's A. **6:** 345-349, Sept. 1951.

(From Episcopal Eye, Ear and Throat Hospital, Washington, D.C.)

The author considers allergy, surgery, hemorrhage, poliomyelitis, therapy, motion sickness, deafness, irradiation of lymphoid tissue, and the therapeutic use of supersonic waves.

Goldberg, Natalie D.: Management of acne cysts. J. Am. M. Women's A. **6:** 349, 1951.

(From New York Infirmary and New York University-Bellevue Medical Center.)

The author describes three methods which can be used with satisfactory results.

Chappell, Amey: The time is the present. J. Am. M. Women's A. **6:** 350-351, Sept. 1951.

Address delivered at inauguration as President, American Medical Women's Association, Atlantic City, New Jersey, June 10, 1951.

Brown, T. McP., Wichelhausen, Ruth H., and others: A study of the antigen-antibody mechanism in rheumatic diseases. Tr. Am. Clin. & Climatol. A. (1950) **62:** 108-119, 1951.

The evidence presented supports the basic theory of hypersensitivity in the pathogenesis of rheumatic diseases. There are indications that cortisone and ACTH block the antigen-antibody reaction without affecting the basic antigen. Studies utilizing human serum albumin have been initiated in the investigation of cortisone action. Authors suggest that the basic antigen in rheumatic diseases is a living agent, invisible in the affected tissue and susceptible to the action of certain antibiotics. Final evaluation of this new approach in the investigation of the basic mechanism must await prolonged clinical trial.

Heilbrügge, T. F., Scheid-Seydel, Lotte, and **Martin, H.:** Die Wirkung von ultra-violetten Strahlen auf die Eiweisskörper des Milchserums [Effect of ultraviolet rays on protein of milk serum]. Ztschr. f. Kinderh. **70**(1): 1-9, 1951.

(From Universitäts-Kinderpoliklinik, München.)

Using electrophoresis and the coagulation method of Weltmann, the effect of ultraviolet rays on the protein in milk serum obtained with the ultracentrifuge was investigated. Changes first appeared in radiation periods of 20 seconds duration and increased with longer radiation. Electrophoretically a leveling-off of the A aud B-globulin fractions could be demonstrated with radiation of short duration; on longer radiation there is also a leveling-off and widening of the albumin fraction. The T-gamma globulin seems to be unchanged even after radiation of 60 minutes. With the aid of the Weltmann coagulation band the stability of the milk serum protein was adversely affected after 40 seconds. The conclusions drawn were that radiation of milk for 0.5 seconds for rickets prophylaxis should exert no measurable effect on milk serum protein.

Dayrit, C., Austria, G. F., Herrera, F., Jr. and **Baltazar, Aida:** Determination of the average single digitalizing dose in Filipinos. Preliminary report. Acta med. Philippina **7:** 263-278, April-June 1951.

(From Department of Pharmacology and Medicine, College of Medicine, University of the Philippines.)

The digitalizing dose was studied in nine patients with auricular fibrillation. The criteria used to determine full digitalization were an atropine response showing predominant extravagal control of the ventricles and absence of toxicity. The average single digitalizing dose of digitoxin administered orally is approximately 1.4 mg. The complexities of digitalization problem are discussed.

Jongco, A. P., Chikiamco, R. S., Felix, Natalia S., and **Lawas, I.:** Spinal fluid findings in Filipino children. Acta med. Philippina **7:** 279-290, April-June, 1951.

(From Department of Laboratories, Philippine General Hospital and College of Medicine, University of the Philippines.)

The spinal fluid was analyzed in different intracranial pathologic conditions. The findings were compared with those in normal children and with findings abroad. In Filipinos these are very similar to those reported in other countries except for a lower sodium chloride value in the Filipinos.

Roche, M., Convit, J., Medina, J. A., and **Blomenfeld, Elena:** The effects of adrenocorticotropic hormone (ACTH) in lepromatous lepra reaction. Internat. J. Leprosy **19:** 137-145, April-June 1951.

(From Cabo Blanco Leprosarium Maiquetía, and Universidad Central, Caracas, Venezuela.)

Six patients with lepromatous leprosy undergoing lepra reaction were given adrenocorticotropic hormone (ACTH, Armour) in doses of 40 to 80 mg. per day for a maximum of seven days. In all cases there was rapid regression of the reaction symptoms and in most the temperature fell to normal within 24 hours. Through rapid control of the reaction symptoms, ACTH may contribute in an important way to the treatment of leprosy, particularly in those cases where the reaction is an obstacle to continued administration of a chemotherapeutic agent.

Spitz, Sophie, and Higinbotham, N. L.: Osteogenic sarcoma following prophylactic roentgen-ray therapy; report of a case. Cancer **4:** 1107-1112, Sept. 1951.

(From Pathology Laboratories and Bone Service, Memorial Center for Cancer and Allied Diseases, New York.)

A case of osteogenic sarcoma arising in the lumbar vertebrae four years following heavy prophylactic million-volt roentgen ray therapy to this area after orchiectomy for seminoma testis, is described. No residual evidence of seminoma was present at autopsy. There is the strong possibility that none was present even prior to roentgen ray therapy in this case.

Forbes, Anne P., and Albright, F.: A comparison of the 17-ketosteroid excretion in Cushing's syndrome associated with adrenal tumor and with adrenal hyperplasia. J. Clin. Endocrinol. **11:** 926-935, Sept. 1951.

(From Department of Medicine, Harvard Medical School, and Medical Service, Massachusetts General Hospital, Boston.)

Ninety cases of Cushing's syndrome in which the adrenals were visualized and 17-ketosteroid assays made, were collected and classified into three groups according to the adrenal pathologic changes. The average 17-ketosteroid excretion of the three groups was: without tumor, 18.1; with benign tumor, 5.7 and with malignant tumor, 124.4 mg. per 24 hours. The pathologic physiology underlying these differences is discussed and certain therapeutic indications mentioned.

Segaloff, A., Sternberg, W. H., and **Gaskill, Cornelia J.:** Effects of luteotropic doses of chorionic gonadotropin in women. J. Clin. Endocrinol. **11:** 936-944, Sept. 1951.

(From Departments of Medicine, Pathology, and Gynecology, Tulane University, the Alton Ochsner Medical Foundation, and Charity Hospital of Louisiana, New Orleans.)

Six women with regular menstrual cycles were treated with 10,000 I.U. daily of chorionic gonadotropin. Delay in the onset of the next menstrual period occurred in all and was accompanied by a decidual change in the endometrium. Urinary findings are described and other morphologic observations.

Perlmutter, M., **Weisenfeld, Shirley,** and Mufson, M.: Comparison of a single G-M tube method and a multitube method of assaying I^{131} uptake by the human thyroid. J. Clin. Endocrinol. **11:** 1012-1020, Sept. 1951.

(From Medical Services, Maimonides Hospital, and Department of Medicine, State University Medical Center at New York, Brooklyn.)

The efficacy of the two methods of assaying the I^{131} content of the human thyroid gland were compared. From the data the single G-M tube method, if used as described, is preferable to the multitube method used in these experiments.

Kinsell, L. W., Olson, F., **Boling, Lenore,** and others: Modification of the clinical and metabolic effects of ACTH by dietary means. J. Clin. Endocrinol. **11:** 1030-1033, Sept. 1951.

(From Institute for Metabolic Research, Highland Alameda County Hospital, Oakland, California.)

In a letter to the editor, a program of evaluation of dietary factors is described in patients to whom ACTH was administered. The findings are discussed.

Gaisford, W., and **Griffiths, Margaret:** B.C.G. vaccination in the newborn; preliminary report. Brit. M. J. **2:** 702-705, Sept. 22, 1951.

(From Department of Child Health, University of Manchester.)

It is both possible and practicable to immunize newborn infants with B.C.G. The reactions, complications, and general findings in a program of immunization in a maternity hospital are described.

Butler, E. Blanche: A case of hypersensitivity to pethidine in a woman in labour. Brit. M. J. **2:** 715-716, Sept. 22, 1951.

(From Bridgend General Hospital.)

Case report.

Brown, Isabell, Eldridge, E., and Gross, A.: Anesthetic management during operation for tetralogy of Fallot. Current Res. in Anesth. and Analg. **30:** 271-277, Sept.-Oct. 1951.

(From Department of Anesthesia, Children's Hospital, Los Angeles.)

A method is described, which was used on 102 patients on whom 106 operations were performed. Preoperative evaluation of congenital heart cases from the viewpoint of the anesthesiologist, together with the anesthetic hazards and techniques are discussed.

Barber, Mary, and Kuper, S. W. A.: Identification of staphylococcus pyogenes by the Phosphatase reaction. J. Path. and Bact. **63:** 65-68, Jan. 1951.

(From Department of Bacteriology, St. Thomas's Hospital Medical School, London.)

Nasal swabs from 100 adults were plated on nutrient agar plus 0.01% phenolphthalein phosphate and incubated overnight. After exposure to ammonia, 42 showed phosphatase-positive staphylococcal colonies and 58 did not. Staphylococcal colonies picked from the 58 negative plates were all coagulase-negative. From the 42 plates showing the phosphatase-positive staphylococci, 160 representative colonies were tested for coagulase and in most cases retested for phosphatase. All but one were coagulase-positive.

Potter, Dorothy: Care of the general health in the middle-aged woman. M. Press **225:** 628-632, June 20, 1951.

(From Harrogate Royal Bath Hospital for Rheumatic Diseases.)

The author discusses obesity, anemia, rheumatic diseases, functional difficulties of the digestive tract, and the menopause. Treatment is briefly considered in each condition.

Weintraub, S., Arons, I., Wright, L. T., **Andler, Lia Rein,** Prigot, A., **Wright, Jane C.,** and Lehv, S. P.: An evaluation of teropterin therapy in metastatic neoplasams. New York State J. Med. **51:** 2159-2162, Sept. 15, 1951.

(From Tumor Service of Harlem Hospital, New York.)

Teropterin is a valuable addition to palliative agents available for use today in the management of incurable cancer. It is nontoxic and has no deleterious side effects. This enhances its worth. Its mode of action is still undetermined.

Dodds, Gladys H.: Urinary infections in pregnancy. Med. Illustrated **5:** 259-264, June 1951.

(From Mothers' Hospital, London.)

The author discusses pregnancy changes in the urinary tract and the etiology of pyelonephritis. Also the pathology, clinical features, clinical types, course, diagnosis, and treatment are considered in some detail. Cystitis is also briefly discussed.

Feninger, Regina: [Primary ovarian carcinoma complicating pregnancy and delivery.] Nord. med. **45:** 61-63, Jan. 10, 1951.

Case is described.

Fallesen, Mary, and Gjerse, Aage: ["Vitana-seccosan"] Nord. med. **45:** 203, Feb. 7, 1951.

Since 1945, Queen Louise Hospital has used a sodium aselnate "seccosan," produced by Ferrosan, Ltd. of Copenhagen, in the treatment of celiac disease and other forms

of severe chronic dyspepsia. Added to buttermilk (vitana) seccosan gives a composition similar to Finkelstein's albumen milk (low fat content of 0.5%) and has been found superior to the latter. The quick and easy preparation involved is also an advantage in post treatment in the home.

Barber, Mary, Brooksbank, B. W. L., and Kuper, S. W. A.: Staphylococcal phosphatase, glucuronidase and sulphatase. J. Path. and Bact. 63: 57-64, Jan. 1951.

(From Departments of Bacteriology and Chemical Pathology, St. Thomas's Hospital and Medical School, London.)

One hundred sixty strains of Staph. pyogenes and 75 of coagulase-negative staphylococci were tested for their capacity to liberate free phenolphthalein from phenolphthalein phosphate, phenolphthalein glucuronide and phenolphthalein sulphate in fluid medium. The findings are discussed.

Kidman, B., Tutt, M. L., and Vaughan, Janet M.: The retention of radioactive strontium and yttrium (Sr^{89}, Sr^{90} and Y^{90}) in pregnant and lactating rabbits and their offspring. J. Path. and Bact. 63: 253-268, April 1951.

(From Department of Pharmacology and Nuffield Department of Medicine, Oxford.)

The results of experiments are described and discussed.

Rountree, Phyllis M., and Barbour, R. G. H.: Nasal carrier rates of staphylococcus pyogenes in hospital nurses. J. Path. and Bact. 63: 313-324, April 1951.

(From Fairfax Institute of Pathology, Royal Prince Alfred Hospital, Sydney.)

This study was made primarily to determine at what stage in their hospital career nurses became carriers of penicillin-resistant strains. The findings are described and discussed.

Hall, Lillian, and Wharton, G. K.: Chloramphenicol (chloromycetin) in the treatment of viral hepatitis. Gastroenterology 19: 69-74, Sept. 1951.

(From Department of Medicine, University of Southern California School of Medicine, and Los Angeles County Hospital.)

Chloromycetin was used in a small series of cases of infectious and serum hepatitis in the Los Angeles County Hospital. One patient who had had recurrent jaundice for four years was given prolonged treatment. For the first time in five years, this patient has been apparently well for six months. Further studies need to be made on this problem.

Filer, L. J., Jr., Wright, S. W., Manning, Mary Parke, and Mason, K. E.: Absorption of a-tocopherol and tocopheryl esters by premature and full term infants and children in health and disease. Pediatrics 8: 328-339, Sept. 1951.

(From Departments of Pediatrics and Anatomy, The University of Rochester School of Medicine and Dentistry, Rochester, N.Y.)

The ability of premature and full term infants in health and disease to absorb vitamin E (tocopherol) was determined using the technique of multiple withdrawals of small samples of capillary blood at three hour intervals following an oral dose of a-tocopherol or a-tocopheryl esters. The results of findings with premature infants, a series of 29 infants whose disease states were diagnosed as fibrocystic disease of the pancreas, diarrhea, and cirrhosis and in a variety of disorders not associated with fat or fat-soluble vitamin intolerance, are given. Findings are also reported in a series of 14 children and 1 adult with sprue, celiac syndrome, and lupus erythematosis. Vitamin A and vitamin E absorption were compared in 10 cases.

Nemir, Rosa Lee, and Israel, J: Pneumococcic meningitis in infants and children; combined therapy using penicillin and sulfonamide. J.A.M.A. 147: 213-218, Sept. 15, 1951.

(From Department of Pediatrics, New York University-Bellevue Medical Center, and Children's Medical Service, Bellevue Hospital.)

Pneumococcic meningitis is no longer a highly fatal disease. A composite study of all cases in infants and children using sulfonamides and penicillin systematically with or without intrathecal therapy gives a recovery rate of 81%. Early diagnosis and age of the patient are important prognostic factors. The clinical experiences described seem to indicate that intrathecal therapy of pneumococci meningitis is not always necessary. Authors suggest that every effort should be made to curtail, if not abandon, intrathecal medication in the treatment of pneumococcic meningitis.

Blocker, T. G., Jr., Blocker, Virginia, and others: Experiences with the exposure method of burn therapy. Plast. and Reconstruct. Surg. 8: 87-93, Aug. 1951.

(From Department of Plastic and Maxillofacial Surgery, The University of Texas School of Medicine, Galveston.)

The results of treating 103 consecutive burn patients by the exposure method were compared with 103 consecutive patients treated with pressure dressings. The exposure method seems to be far superior to the method with dressing. The authors describe their results and also the effects of ACTH and cortisone in the healing of burns.

Bacher, Wilhelmina C., and Hertzog, A. J.: Bilateral ovarian carcinoma arising in endometrial cysts; report of a case. Am. J. Clin. Path. 21: 965-968, Oct. 1951.

(From Department of Pathology of Touro Infirmary, New Orleans.)

A case of bilateral carcinoma arising in ovarian endometrial cysts is reported. The authors could find no record of any other case reported in the literature.

Russ, Ella M., and others: Protein-lipid relationships in human plasma: 1. in normal individuals; 2. in atherosclerosis and related conditions. Am. J. Med. 11: 468-479; 480-493, Oct. 1951.

(From Department of Medicine, New York Hospital-Cornell Medical Center, New York.)

The Cohn microfractionation method no. 10 for the separation of proteins was applied to the plasma of 85 presumably normal individuals ranging in age from 18 to 65 years. Confirmatory evidence was offered to support the thesis that essentially all of the cholesterol and phospholipid of plasma is combined with protein in the form either of alphat lipoproteins or beta lipoprotein. Single or multiple studies were also made on 33 patients known or thought to be suffering from complications of atherosclerosis, 2 who exhibited advanced lesions of familial xanthoma tendinosum with hypercholesterolemia, 35 diabetics, and 12 nephrotics. The findings are summarized and tabulated and conclusions are drawn.

Forshall, Isabella, Rickham, R. P., and Mossman, D. B.: Functional intestinal obstruction in the newborn. Arch. Dis. Child. 26: 294-299, Aug. 1951.

(From Royal Liverpool Children's Hospital.)

Functional intestinal obstruction of the newborn affecting several members of one family is described. The possible relationship of this condition to Hirschsprung's disease and the treatment are discussed. The authors suggest that functional intestinal obstruction in the newborn, with or without a familial basis, is a definite clinical and pathologic entity.

Mann, Ida: Recent cancer research and its relation to ophthalmic and other clinical problems. Australian and New Zealand J. Surg. 21: 52-60, Aug. 1951.

After a brief mention of past research, the author discusses new ideas and developments. Included among these are activators, properties of viruses, life cycles of viruses, virus tumors of birds, and mammals. The practical applications of all the new findings with regard to ophthalmology are considered.

Young, Winifred F., Smith, Gwen, and others: Trials of oral streptomycin for infants with non-specific gastroenteritis. 2. Trials at the Queen Elizabeth Hospital, Hackney. Brit. M. J. 2: 770-774, Sept. 29, 1951.

(From Queen Elizabeth Hospital for Children, Hackney.)

Trials of oral streptomycin for infants under one year suffering from endemic non-specific gastroenteritis extended in three stages over the period from Aug. 1947 to February 1950. The main stage of the investigation included 97 babies grouped according to age and severity of their disease, alternate cases in each age group being allocated to the trial and control series. No clear-cut

response to streptomycin was demonstrated but data show slightly better progress among streptomycin-treated cases and more marked contrast among the severe cases. Many cases failed to respond to streptomycin and it cannot be regarded as an effective therapeutic agent for the disease. Bacteriologic studies throw no light on the etiology of gastroenteritis. Streptomycin in the dosage used failed to eliminate the special type B.coli, alpha and beta.

Van Went, Johanna M.: Is it possible to substitute ACTH? Brit. J. Phy. Med. **14:** 227-231, Oct. 1951.

Stimulation of the hypophysis by means of ultra-short wave therapy was tried on 20 patients in an attempt to substitute this for ACTH. The results are summarized. For three cases these results are tabulated showing details.

Mullinger, Margaret, and Chute, A. L.: Adrenal insufficiency in childhood. Canad. M.A. J. **65:** 353-357, Oct. 1951.

(From Wards and Laboratories, Hospital for Sick Children, and Department of Paediatrics. University of Toronto, Faculty of Medicine, Toronto, Ontario.)

The literature on adrenal insufficiency in childhood is reviewed and two cases are reported. In one case implantation of pellets of desoxycorticosterone acetate proved to be life-saving, and the child is apparently well and active 29 months after the initial treatment.

Albrink, Margaret J., Parente, L., and Gelperin, A.: Results of a diabetes detection drive. Connecticut State M.J. **15:** 897-899, Oct. 1951.

(From Department of Public Health of Yale University, and Health Departments, Hamden and New Haven.)

In a recent drive in the New Haven area, urinalyses for sugar were done on 1025 persons or 0.5% of the population. The findings and benefits of such a detection drive are discussed.

Dormer, B. A., **Greathead, Elizabeth,** and others: Postural rest in pulmonary tuberculosis. Dis. Chest, **20:** 407-419, Oct. 1951.

From our short experience of this form of treatment, and despite the relatively few patients who give their complete co-operation, it has been the impression throughout the hospital that the response to postural rest far outweighs that of ordinary bed rest and appears to deserve more wholehearted approval and acclaim than any other single method of treatment.

Mickle, K. C., Muscato, G. V., **Lemanski, Alice,** and Claudon, D. B.: Treatment of leukemia in childhood. J. Pediatrics, **39:** 442-447, Oct. 1951.

(From Hematology Service of Milwaukee Children's Hospital, Milwaukee.)

Results of treatment in 22 cases are reported. Therapeutic agents used were folic acid antagonists, adrenocorticotropic hormone, cortisone, transfusion, and antibiotics. Characteristic laboratory changes are also reported. Aminopterin is a drug possessing therapeutic value but extreme toxicity. Limited experience with ACTH and cortisone showed them to be of less value than aminopterin in the treatment of acute leukemia in children.

Pittman, Helen Sinclair, and Kane, L. W.: Fungus infections of the lungs. M. Clin. North America. pp. 1323-1331, Sept. 1951.

(From Pulmonary Clinic, Massachusetts General Hospital, Boston.)

Actinomycosis appears to be the most common fungus disease involving the lungs seen in the Boston area. The use of the sulfonamides and antibiotics has produced a revision of our ideas concerning management and prognosis of this disease. The possibility of this diagnosis should be considered in cases of obscure chronic pulmonary disease. Five cases of coccidioidomycosis were seen. All gave a history of travel in the southwestern part of the United States. One case proven bacteriologically had a negative skin test.

Brown, Madelaine Ray: The classification and treatment of headache. M. Clin. North America, pp. 1485-1493, Sept. 1951.

(From Massachusetts General Hospital; New England Hospital, Boston; and Mt. Auburn Hospital, Cambridge.)

The case records of seven patients with headache were outlined. Diagnoses comprised the following: ruptured congenital aneurysm of an intracranial artery, cranial (temporal) arteritis, subdural hematoma, paroxysmal sick headache (migraine), headache with hypertension, headache due to compensation neurosis following head injury, and headache due to psychologic stress. The treatment used was outlined after the case record of each patient.

Snow, Lucille: Carcinoma of the cervix. M. Woman's J. **58:** 7-12, Jan.-Feb. 1951.

(From Department of Obstetrics and Gynecology, Stritch School of Medicine, Loyola University, Chicago.)

General discussion of classification and treatment.

Titcomb, Lillian Ray: Why and how we help parents train blind babies. M. Woman's J. **58:** 20-25, Jan.-Feb. 1951.

(From Nursery School for Visually Handicapped Children, Los Angeles.)

General discussion of methods with illustrations of specific cases.

Klenerman, Pauline: Nutritional edema—a survey of cases at King Edward Hospital, Durban, South Africa. M. Woman's J. **58:** 20-23; 35, March-April 1951.

Data are tabulated and discussed. Methods of treatment and the socio-economic problem involved are considered.

De Solis Quiroga, M. Delgado: The importance of Mexico's materno-infant hygienic centers, M. Woman's J. **58:** 24-25, March-April, 1951.

General discussion.

Campbell, Kate: Intensive oxygen therapy as a possible cause of retrolental fibroplasia: a clinical approach. **M. J. Australia, 2:** 48-50, July 14, 1951.

Author suggests that normal oxygen environment of the newborn full-term infant is abnormal for the premature infant, in particular for infants of 32 weeks' gestation or less. The potential toxic effect of oxygen on premature infants can be enhanced by administration of a high concentration of oxygen therapeutically, by pyrexia, by toxemia. The generalized vascular spoiling and edema so produced affect the eye and are the starting points of retrolental fibroplasia. Prophylactic measures are given on the basis of these suggestions.

Gale, J. W., **Dickie, Helen,** and Curreri, A. R.: Resection in the treatment of pulmonary tuberculosis. Southwest, Med. **32:** 266-269, Aug. 1951.

(From University of Wisconsin, Madison.)

The overall experience with a group of 80 resected cases has been most gratifying. More than 50 percent received all the collapse possible. This had proved inadequate. Resection cannot be criticized as an ineffective procedure because it fails. All procedures have failed in the past.

Smoller, S., Schreiber, H., and **Scott, Beatrice:** Trichobezoar as cause of intestinal obstruction in a two-and-a-half-year-old child. A.M.A. Am. J. Dis. Child. **82:** 439-441, Oct. 1951.

(From Pediatric and Surgical Services, Harlem Hospital, New York.)

A case of intestinal obstruction caused by trichobezoars without a gastric component is presented. The clinical picture described appears to be typical of hairball obstruction and should be considered in the differential diagnosis of intestinal obstruction in children.

PICTURE CREDITS

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EDITORIAL FORECAST

December 1952

"The Story of Kwashiorkor," by Elinor Downs, M.D.

"Importance of Potassium," by Esther M. Greisheimer, M.D., Ph.D.

"Health Services for Mothers and Children: Current Trends," by Helen M. Wallace, M.D.

"The Voluntary Respiratory Mechanism in Bulbar Poliomyelitis," by Hulda E. Thelander, M.D.

"Some Aspects of the Microbiology of Cancer," by Virginia Wuerthele-Caspé, M.D., Eleanor Alexander-Jackson, Ph.D., and Lawrence Weld Smith, M.D.

And "The Psychosomatic Outlook of Doctors Abraham and Mary Putnam Jacobi," by Eugene P. Link.

There will also be a review of the Fifth Session of the Southeast Asia Regional Committee of the World Health Organization which met in September in Badung. This includes the high lights of the report given by Dr. Chandra Mani, its Regional Director.

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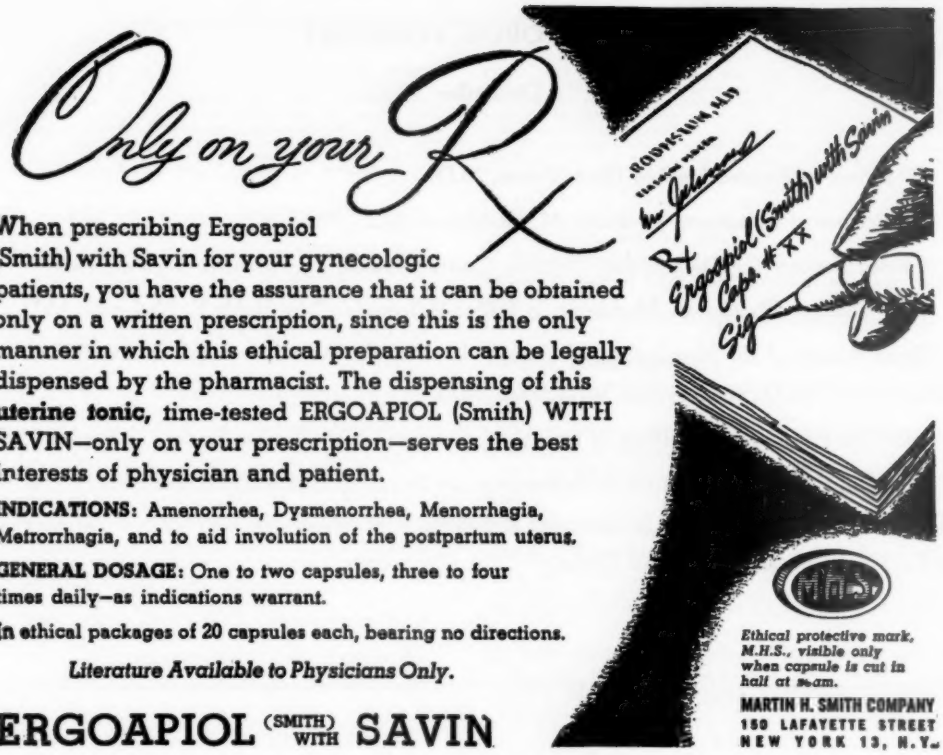
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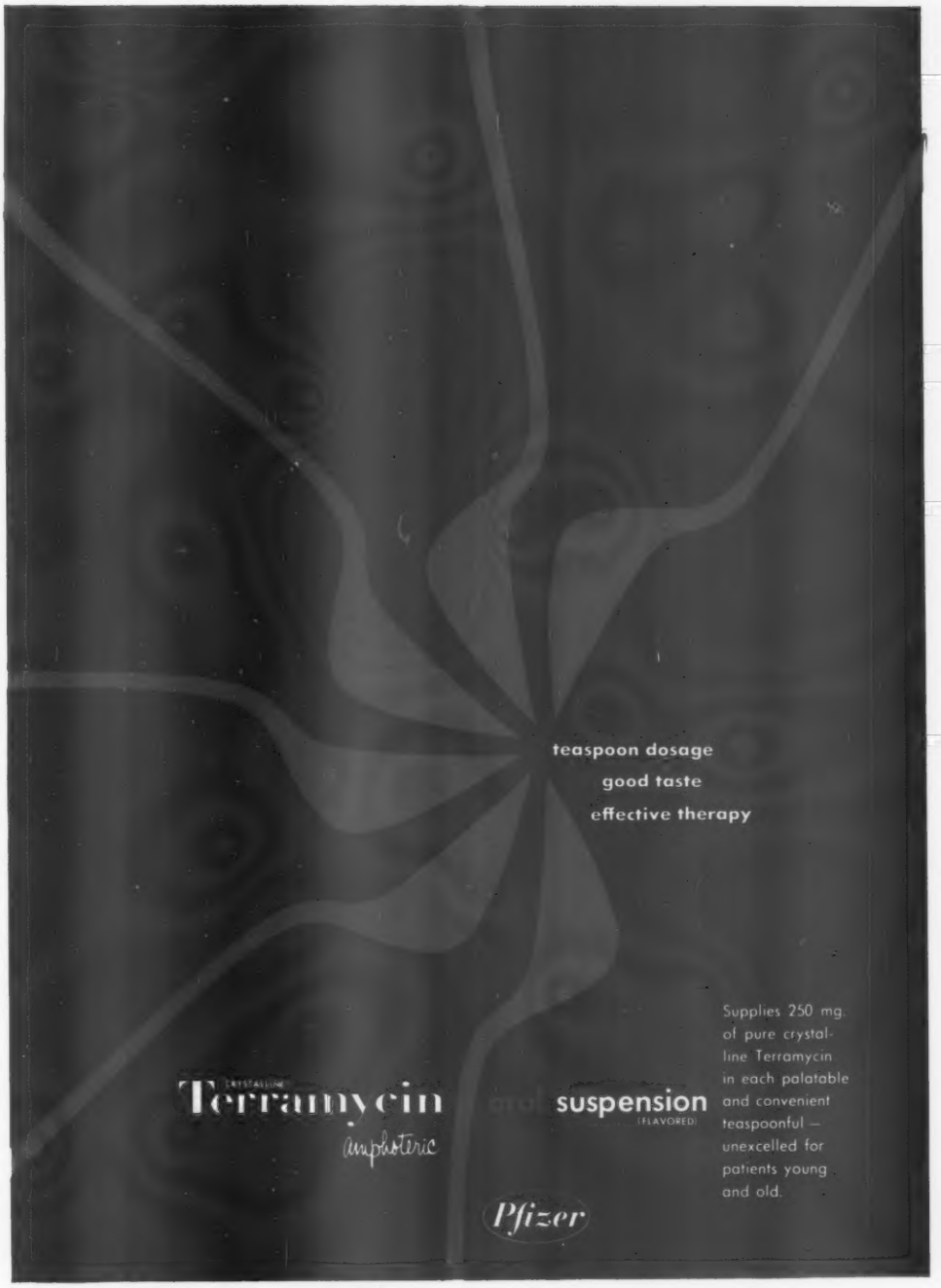

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